

**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT J  
TO COMPLAINT  
FILED FEBRUARY 28, 2023

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## CLINICAL ARTICLES

When A Fever Is  
Not A URI: If It's Not  
In The Differential, It  
Won't Be In The  
Diagnosis



## When a Fever is Not a URI: If It's Not in the Differential, It Won't Be in the Diagnosis

### WEB EXCLUSIVE

What Qualifies  
Someone To Take X-  
Rays In The Urgent  
Care Center? It All  
Depends On Where  
You're Located

### CASE REPORTS

An Unusual Case Of  
Third And Fourth  
Metacarpophalangeal  
Joint Dislocations  
Following A Fall

### HEALTH LAW

Who Can Take X-  
Rays In An Urgent

### IMAGES CHALLENGE

A 10-Year-Old Boy

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## URGENT CARE NEWS

### Update: Amoxicillin and Clavulanate Products Will Continue to Be in Short Supply

JUCM News reported nearly a month ago on a scarcity of oral presentations of amoxicillin ...

### The Early Winter Forecast: Chilly with a Chance of COVID

As temperatures fall in much of the United States new hospitalizations for COVID-19 are expected ...

### Free JUCM Webinar: STI's Are Heating Up. Find Out What Role Urgent Care (and You) Can Play

As cases of COVID-19 (and restrictions like social distancing) took hold in the United States, ...

### Showing That You 'Understand' Individual Patients Could Go a Long Way Toward Ensuring Their Satisfaction

Everybody wants to be recognized and understood—whatever that means in a given scenario. When that ...

### Nurse Practitioners Are Inching Closer to Independence from Physician Oversight

The contributions of nurse practitioners and physician assistants (known collectively as advanced practice providers, or ...

## WEB EXCLUSIVE ARTICLES

### Code Case Files: An Established Adult Male Patient with 2 Days of COVID-Like Symptoms

Bradley L. Laymon, PA-C, CPC, CEMC PRESENTATION A 47-year-old established male patient presented after 2 ...

### What Qualifies Someone to Take X-Rays in the Urgent Care Center? It All Depends on Where You're Located

### Repairing Parallel Lacerations in the Urgent Care Center

### Mysterious Skin Lesions in a Horse Trainer

### Getting the Most Out of Your Urgent Care Google Ads Budget in 2022

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## CLINICAL ARTICLES

When a Fever is Not a URI: If It's Not in the Differential, It

<https://www.jucm.com>

## PRACTICE MANAGEMENT ARTICLES

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11/26/22, 7:24 PM

Journal Of Urgent Care Medicine - Journal of Urgent Care Medicine

## Won't Be in the Diagnosis

Urgent message: Fever in patients presenting to UC is often attributable to viral infections, urinary tract infections, otitis media, cellulitis, ...

## Is It Appendicitis? The Role of Clinical Scoring Systems, Labs, and Diagnostic Imaging

Urgent message: Ultrasound can provide essential data in the urgent care evaluation of suspicion of acute appendicitis. Facilitating a rapid ...

## A Legal Quandary: A Diagnosis of Cellulitis...That Isn't

Michael Weinstock, MD; Gabby Gostigian, MD; and Matthew Delaney, MD Urgent message: Failure to consider subtleties and the context in ...

## Where Should I Refer My Spinal Patient? Outcomes with Orthopedic and Neurosurgeons for Common Neck and Back Procedures

Urgent message: Neck and back pain are common issues preceding surgical intervention. Given differences in care plans, outcomes, cost, and ...

## DOT Physicians and Urine Drug Testing Represent a Growth Opportunity for Urgent Care Centers

Urgent message: Demand for DOT-related services for truck drivers is soaring. Urgent care centers can augment traditional insurance-paid visits with ...

## Find Prime Locations for Rapid Urgent Care Growth

Urgent message: Using a data-driven approach to predict performance, taking advantage of openings in traditional retail spaces, or utilizing resources ...

## As COVID Turns Endemic, Investors Remain Bullish on Urgent Care Growth

Urgent message: De novo growth of urgent care continued through the pandemic. As COVID turns endemic, investors remain bullish on ...

## Why Private Equity and Other 'Smart Money' Is Bullish on Brick-and- Mortar Urgent Care

Urgent message: Despite the current seasonal, postpandemic lull in volume, sophisticated investors are focused on the long-term growth prospects of ...

# INSIGHTS IN IMAGES CHALLENGES



## JUCM CAREER CENTER

**Physician House Calls Program New York City, Long Island, Northern Westchester, Staten Island, Bronx, and Brooklyn**  
Brooklyn, NY - Northwell Health

**Internal Medicine: Pediatrics - Elizabethtown, KY - Paducah, KY - Recruiting Incentives up to \$200,000**  
Elizabethtown, KY - Baptist Health Medical Group

**Excellent PT or FT opportunity for Family Practice Physicians**  
Hampstead, MD - LifeBridge Health

**STAFF PHYSICIAN - GENERAL PEDIATRICS**  
Hershey, PA - Penn State Health Children's Hospital

**Family Medicine or Internal Medicine Recruiting Incentives up to \$200,000**  
Paducah, KY - Baptist Health Medical Group

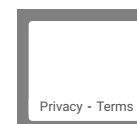
**Family Medicine - Kentucky and Southern Indiana - Find optimal work-life balance and a lucrative recruitment package in the Beautiful Bluegrass Region - Recruiting Incentives up to \$200,000**  
KY - Baptist Health Medical Group

**Urgent Care Veterinarian**  
Northampton, MA - Integrity Veterinary Center

**Urgent Care - Nurse Practitioner**  
TEMPLE, TX - Baylor Scott & White Health

**Employed Family Medicine Employment Opportunities in Virginia + STUDENT LOAN INCENTIVES**  
Roanoke, VA - Carilion Clinic

**Family Medicine Physicians**  
St. Johnsbury, VT - Northeastern Vermont Regional Hospital



## DOWNLOAD PAST ISSUES

**November 2022** : Broadening the Differential for Fever - Etiologies Beyond Infection



October 2022



September 2022



July-August 2022



June 2022

[VIEW ISSUES ARCHIVE](#)

### CASE REPORTS

#### An Unusual Case of Third and Fourth Metacarpophalangeal Joint Dislocations Following a Fall

Urgent message: Metacarpophalangeal dislocations involving digits other than the thumb or index finger may be somewhat ...

#### Bullous Pemphigoid Reaction After Second Dose of COVID-19 Vaccine

#### A Rare Case of Sequential Simultaneous Bilateral Mandibular Fractures

#### Brain Abscess in an Immunocompetent Patient:

### HEALTH LAW

#### Who Can Take X-Rays in an Urgent Care Center?

Urgent message: Given that x-ray is a differentiating feature of "urgent care" and the current challenges ...

#### What Qualifies Someone to Take X-Rays in the Urgent Care Center? It All Depends on Where You're Located

#### Avoiding Defamation Lawsuits in Urgent Care

#### Can PAs and NPs Unionize in Urgent Care Settings?

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Journal Of Urgent Care Medicine - Journal of Urgent Care Medicine

**Complex Pathology and Communication****How Useful Is Ultrasound in Diagnosing Ovarian Torsion?****What's the Best Policy for Unlocking an Urgent Care's Doors when a Provider isn't Present?****CLINICAL CHALLENGES****An 83-Year-Old Female with CHF, A-Fib, and New-Onset Confusion and Syncope**

An 83-year-old female with past medical history of congestive heart failure and atrial fibrillation presents to urgent care with confusion ...

**A 9-Year-Old Girl with a New Rash on Her Face****A 40-Year-Old with Back Pain After a Fall****A 45-Year-Old Male with Palpitations****A 43-Year-Old with a New Rash on the Trunk****OCCUPATIONAL MEDICINE****Update: The COVID-19 Vaccine Mandate for Many Businesses Is Off—Again**

Just when you thought you had clarity on the Occupational Safety and Health Administration's mandate to vaccinate workers at businesses ...

**That Vaccine Mandate for Private Businesses That Was Called Off? It's on Again—and the Clock Is Ticking****Your Occ Med Clients Need Your Support with the New COVID-19 ETS—Immediately****More People Are Trudging Off to Work on Site. Do You Know Who's at Greatest Risk for COVID-19?****As Travel Opens Up, Opportunities to Offer COVID-19 Tests Could Be Lucrative****REVENUE CYCLE MANAGEMENT****Where Do You Start When Starting Your Urgent Care?**

Heather Real There are many reasons to start your own urgent care, whether it be feeding your entrepreneurial spirit, investing ...

**New ICD-10-CM Codes in Effect as of October 1****Primed for Growth: Why It's Time to**

<https://www.jucm.com>

**DEVELOPING DATA****Urgent Care Is Correcting Course on Antibiotic Prescribing**

Just 4 years ago, a Research Letter published by JAMA Internal Medicine painted an unflattering picture of the antibiotic prescribing ...

**The Data Are Clear: Urgent Care Visits Almost Always Suffice for Low-Acuity Cervical Trauma**

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**Consider Adding Primary Care Services to Your Urgent Care Center**

**A Half Century of Urgent Care: What Today's Startups Need to Know**

**Decreasing Denials and Rejections Through Your Urgent Care Operating Model**

**A Tale of Two Viruses: Rapid Flu and COVID-19 Tests in the Urgent Care Setting**

**Urgent Care—It's a Millennial's Market**

**Spoiler Alert: 2020 Saw a New Trend in Urgent Care Data Claims**

## ABSTRACTS IN URGENT CARE

### Abstracts in Urgent Care November 2022

Fever: To Treat or Not to Treat?  
Distinguishing Viral from Bacterial  
Conjunctivitis  
Scapular Fractures and Blunt  
Chest Trauma in Children  
Sterile vs  
Nonsterile ...

### Abstracts in Urgent Care - October 2022

### Abstracts in Urgent Care - September 2022

### Abstracts in Urgent Care - July/August 2022

### Abstracts in Urgent Care - June 2022

## LETTER FROM THE EDITOR-IN-CHIEF

### The Value of Repeat Vital Signs

Joshua Russell, MD, MSc, FCUCM, FACEP  
I'm just going say it: we should repeat  
vital signs more often in urgent ...

### The Value of Vitals - Part I

### Antibiotic Prescribing in "Gotham City"

### Playing in the Band

### Addressing Without Managing: Defusing the Ticking Time Bombs in Urgent Care

## ABOUT US

The Journal of Urgent Care Medicine® (JUCM) is the official journal of the Urgent Care Association (UCA). Each issue contains a mix of peer-reviewed clinical and practice management articles that

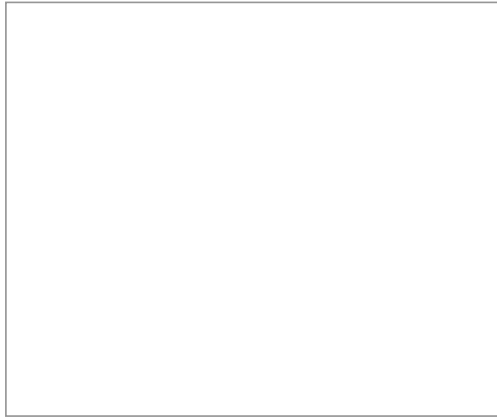
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address the distinct clinical  
and  
practice management  
needs of those who are  
working in today's busy  
urgent care centers.  
JUCM's reach of over  
42,000 includes qualified  
clinicians, business and  
administrative  
professionals working in  
urgent care facilities  
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Defendants.

\_\_\_\_\_ /

EXHIBIT K  
TO COMPLAINT  
FILED FEBRUARY 28, 2023

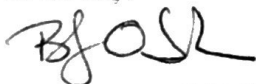
December 2, 2021

Hello Dr. Stanley:

I came across your June 1, 2021 article (**An Urgent Care Approach to Fishhook Removal**) online, early October, on the Journal of Urgent Care Medicine website. It seemed like a timely article that would summarize all the current ways to remove a fishhook. I wanted to use it for our Urgent Care Journal Club meeting, upon reading the article I noticed multiple typographical errors. I was very disappointed, and had difficulty trying to comprehend the written subject matter, and follow along with the photos which are not synchronized with the reading. You also alluded to the fact that there needs to be more research in fishhook injury and related demographics. However, the discussion seemed disconnected somehow. Lastly, you talked about a new concept, a fishhook removal system but the discussion was limited. Over all, it was poorly written by you as a physician and author. The JUCM should share the blame for not proof reading. It's a great topic but needs to be presented to the medical community properly. I am a monthly reader of the JUMC and surprised of this body of work they released to the medical community! I have read several medical journals with mistakes in the past and like them, in this case, it should be corrected and reprinted. I would love to have presented this article "**An Urgent Care Approach to Fishhook Removal**" to Journal Club at our urgent care.

I was hesitant to contact you, but just felt you should know.

Sincerely,

A handwritten signature in black ink, appearing to read 'BJS', with a stylized flourish at the end.

Bonnie Jean O'Sullivan, MD

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COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT L  
TO COMPLAINT FILED  
FEBRUARY 28, 2023

**From:** Raisa K. Barros <[RaisaB@baptisthealth.net](mailto:RaisaB@baptisthealth.net)>

**Sent:** Wednesday, November 24, 2021 10:28

**To:** [tuff57@msn.com](mailto:tuff57@msn.com)

**Subject:** Journal Complaint

Dr. Stanley,

I would like to share some feedback regarding your article "An Urgent Care Approach to Fish Hook Removal" in the Journal of Urgent Care Medicine printed June 1, 2021. I found it in the break room at our Urgent Care and I was very interested in the subject as this is a very common patient visit in my patient demographic area. I have to mentioned that I was very surprised and disappointed as in my opinion the article was poorly written. The article, has multiple errors and the sentences do not make sense in a lot of the sections. The pictures are printed in such poor quality, and out of order. I made it difficult to follow the recommended procedures. You are supposed to be an expert in the subject, I am surprised you did not proof read your work before submitting it to a Premier Medical Journal like the Journal of Urgent Care Medicine. I am also sending a copy of this letter to the Journal for not checking what they printed. I hope you consider my feedback for any future work you publish.

Respectfully,

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an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT M  
TO COMPLAINT FILED  
FEBRUARY 28, 2023

**From:** Aquino, Jennifer <[Jennifer.Aquino@mountsinai.org](mailto:Jennifer.Aquino@mountsinai.org)>  
**Sent:** Tuesday, November 23, 2021 11:05 AM  
**To:** Anthony G. Stanley <[AnthonyS@baptisthealth.net](mailto:AnthonyS@baptisthealth.net)>  
**Subject:** [External] FW: Complaint letter

Dear Dr. Anthony Stanley:

My name is Jennifer Aquino, ARNP. I am writing to inform you, I came across your June 1, 2021 article on fish hook removal in the Journal of Urgent Care Medicine (JUCM) entitled "An Urgent Care Approach to Fish Hook Removal". I saved the article for that possible situation of getting a patient in the urgent care with a fish hook injury. I have rarely seen the injury but felt assured that the JUCM would have the best information. On October 2nd, 2021, I was at work and a patient came in with a fish hook injury to the palm of his hand. Before going into the room I took 5 minutes to review the article and its suggested approaches. Upon finally reading the article I was shocked of the typographical errors and disjointed statements located in the article.

The pictures were so small and outlined with such bright colors that distracted me from focusing and comprehending what to do. Also, the instructions and the related photos were out of place and made everything difficult to comprehend. I am sorry to say I was disappointed with your writing and you

1/9/22, 4:21 PM

Chase Lawyers Mail - FW: [External] FW: Complaint letter

should take a course in journalism. I am surprised the JUCM published this article. I had to send the patient to the emergency room for fish hook removal and I looked very bad for not being able to perform the procedure. The patient also wrote a discouraging letter to my supervisor about me as a practitioner. It took some time to locate you, but.

Thought you should share in my sorrow!

Cordially

Jennifer Aquino, ARNP

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Defendants.

\_\_\_\_\_ /

**EXHIBIT N  
TO COMPLAINT FILED  
FEBRUARY 28, 2023**





October 10, 2021

Dear Dr. Stanley:

As you know each year in October, my company is the host of an annual Out-Patient Procedures Course to in-service our medical staff of over 150 Physicians, ARNP's, PA's, in addition we reach out to community physicians in need of medical procedure education. On May 3rd, 2021, you and I discussed your participation in a paid faculty position as an authority in the field based on your upcoming article in the JUCM. As you know we are considering, making this program a monthly course. In a private meeting I offered you an ongoing faculty position and salary of \$2,500 per month to lecture on the contents of the article at our various venues, and a monthly royalty fee of \$500.00 monthly for the term of one year, to use the contents of your copyrighted article and medical illustrations as we saw fit, and for future ads. The educational committee this year learned of your article entitled **An Urgent Care Approach to Fish Hook Removal** published in the June issue of the **Journal of Urgent Care Medicine** and submitted it for review to be implemented in our educational platform. I am sending you this letter to inform you that I can no longer support the use of this article due to its printing of medical misinformation, multiple grammatical errors, poor editing and poorly displayed medical illustrations.

The committee found the format used was not professionally suitable for the use of our attendees, and subsequently cannot be referenced in our take home materials nor placed on our purposed website as a creditable source of medical information. I sorry to inform you of this decision by the committee. I will not be able to honor any financial considerations previously discussed, nor afford you a place on the lecture podium this year. Time is of the essence for preparing our course curriculum and this position will be offered to another candidate. The arrangement counted on your listing in the Journal of Urgent Care Medicine, establishing your creditable authorship. As you know all lectures on our program must have published creditable articles on their topic. Your current JUCM article on-line and in print does not meet our requirements to be a part of the lecture staff. The participants of our program appreciate the authenticity of the material being presented to them to use safely and reliably in their patient care practice. If you are able to present the committee with a creditable article printed in an acceptable medical journal I will reconsider this offer at a later date.

Cordially,

A handwritten signature in blue ink, appearing to read "William Kranichfeld", is written over a horizontal line.

Dr. William Kranichfeld

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EXHIBIT O  
TO COMPLAINT FILED  
FEBRUARY 28, 2023

From: **Barry Katzen** <[BARRYK@baptisthealth.net](mailto:BARRYK@baptisthealth.net)>  
Date: Wed, Apr 6, 2022 at 12:04 PM  
Subject: RE: FW: [External]  
To: Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>  
Cc: Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>

Dr. Stanley,

We have reviewed this opportunity in detail and tried to share with you the information collected during the process. Unfortunately, Innovations will not be able to move forward on this device, but wish you success moving forward and hope the analytics done by us might be helpful to you moving forward. Keep working on new ideas!

Barry

Barry T. Katzen, MD, FACC, FACR, FSIR

Founder and Chief Medical Executive | Miami Cardiac & Vascular Institute

Chief Medical Innovation Officer | Baptist Health South Florida

Assistant: Lisa Gordon 786-662-7754

1500 San Remo Avenue, Suite 125I Coral Gables, Florida 33146

Direct: 786-662-7787 | Mobile: 305-773-4060

[BarryK@baptisthealth.net](mailto:BarryK@baptisthealth.net) | BaptistHealth.net



Professor and Chairman

Department of Interventional Radiology

Herbert Wertheim College of Medicine

Florida International University





---

**From:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Sent:** Wednesday, April 6, 2022 11:02 AM  
**To:** Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>  
**Cc:** Barry Katzen <[BARRYK@baptisthealth.net](mailto:BARRYK@baptisthealth.net)>  
**Subject:** RE: FW: [External]

Hello Dr. Stanley,

Thanks for your note. Let me touch base with Dr. Katzen and we will get back with you.

Best,

Nila

**From:** Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>  
**Sent:** Thursday, March 31, 2022 10:08 AM  
**To:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Subject:** Re: FW: [External]

Hello Nila: Thank you for the information. Would Innovations be interested in partnering in hemostat development?

Thanks

Dr. Stanley

On Wed, Mar 30, 2022 at 11:06 AM Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)> wrote:

Dr. Stanley,

As promised, please find the market landscape for your Hybrid Hemostat Invention. In addition, I asked the group to see if they could quantify the issue of fishhook injuries, and I think they did a pretty decent job.

Take a look and let me know if you have any questions.

Best,

Nila

---

**From:** Maureen Wilson <[mwilson@firstlinkanalytics.com](mailto:mwilson@firstlinkanalytics.com)>  
**Sent:** Wednesday, March 30, 2022 10:52 AM  
**To:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Cc:** Brittany Shaffer <[bshaffer@firstlinkanalytics.com](mailto:bshaffer@firstlinkanalytics.com)>  
**Subject:** Re: [External]

Hi Nila,

Attached is the Hybrid Hemostat Market Landscape, a supplemental 2-pager, and information we found regarding fishhook injuries. The key findings for the Hybrid Hemostat Market Landscape include:

- There appear to be a total of **10 solutions** that offer similar features to the proposed invention.
- **Integra LifeSciences Corporation's (MicroFrance) solution appears to be the only one that has the unique feature of a medical tool combined with a measuring device. However, it is designed to be used only in the field of otology, which limits its application.**
- Since proper and timely insurance reimbursement may be contingent upon accurate reporting of medical procedure details, such as the dimensions of embedded objects, wounds, and the like, the proposed invention can assist in this regard due to its unique measuring feature.
- There are two relevant markets for the proposed invention, the global market for handheld surgical instruments and the global hemostats market.

Additionally, in regards to fishhook injuries, we found that:

- There is little data on the prevalence of fishhook injuries in the United States. The best estimate is **500,000 to 1 million injuries related to fishhooks each year.**
  - Uncounted are the numerous hooks removed by the injured anglers themselves or by their fishing buddies. Removal advice isn't hard to find.
- Some hospitals state that they treat **90 to 100 patients with embedded fishhooks each year.**
- There are approximately **60 million anglers in the U.S.** of which 46 million are estimated to fish in a given year.
- **Florida is the number one ranked state for fishing** and the number one ranked state for non-resident fishing destinations.

Please let us know if you have any questions on any of this information!

Thank you,

Maureen

On Feb 23, 2022, at 8:37 AM, Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)> wrote:

Hi,

Can you do a market assessment for this product?

And is there any way you can determine how many people get hooked with fishhooks in the US, rest of the world?

Thanks,

Nila

---

**From:** Nila D. Bhakuni  
**Sent:** Tuesday, January 25, 2022 9:55 AM  
**To:** Carla Garic <[Carla.Garic@baptisthealth.net](mailto:Carla.Garic@baptisthealth.net)>  
**Cc:** Stephanie Parra <[Stephanie.Parra@baptisthealth.net](mailto:Stephanie.Parra@baptisthealth.net)>; Daeanne Alvarez Cruz <[Daeanne.AlvarezCruz@baptisthealth.net](mailto:Daeanne.AlvarezCruz@baptisthealth.net)>  
**Subject:** FW: [External]

A new project – new hybrid hemostat

Anthony Stanley has submitted other project ideas to us so there are related projects.

Project Manager is Stephanie Parra

Person internally right now is Barry Katzen.

Stephanie, please ask Barry if he can give you a subject matter expert for this case to review this material.

Nila

**From:** Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>  
**Sent:** Monday, January 24, 2022 3:18 PM  
**To:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Cc:** Bill M. Duquette <[BillD@baptisthealth.net](mailto:BillD@baptisthealth.net)>; Barry Katzen <[BARRYK@baptisthealth.net](mailto:BARRYK@baptisthealth.net)>; Stephanie Parra <[Stephanie.Parra@baptisthealth.net](mailto:Stephanie.Parra@baptisthealth.net)>; Lisa Gordon <[lisag@baptisthealth.net](mailto:lisag@baptisthealth.net)>; Caroline Mauriello <[CarolineM@baptisthealth.net](mailto:CarolineM@baptisthealth.net)>; Daeanne Alvarez Cruz <[Daeanne.AlvarezCruz@baptisthealth.net](mailto:Daeanne.AlvarezCruz@baptisthealth.net)>; Carla Garic

<[carla.garic@wellspring.com](mailto:carla.garic@wellspring.com)>

**Subject:** Re: [External]

1/24/2022

Dear Innovations:

This is Dr. Stanley with another medical device that I am desiring to bring to fulfillment. My **second invention** is a **new hybrid hemostat** approved by the US Patent office for measuring while in surgical procedures. During surgical procedures, the need often arises to measure distances of a relatively small size such as puncture depths, foreign object sizes, wound sizes, abscess sizes, and the like. Such dimensions are often necessary to gauge the level and type of care required for a patient. Moreover, this need is also becoming necessary for administrative purposes. For instance, proper and timely insurance remuneration can depend upon the accurate reporting of the details of a medical procedure including the dimensions of embedded objects, wounds, etc. This device can perform multiple surgical functions and uniquely give the provider the option to measure simultaneously.

I am in the development phase of the project and this may be an opportunity for **Baptist Health South Florida** to partner with me in bringing this new medical device to its full potential. As you are aware I recently presented my first medical invention to the **Innovations division, a special wire cutter which was able to catch cut fragments and prevent them, from flying across the surgical table**, called a” **Moby Cutter**” of which I was informed was too close to the “purchasing phase”, **and not a potential co-development opportunity.**

I am enclosing a copy of the **second invention Patent** for your review. I would like an opportunity to come in and meet with the Innovations staff to present my second medical device plans. **I have been associated with Baptist Health South Florida since 1997. My**

**specialty outside of Emergency Medicine Services for Baptist Health South Florida, is developing ways to make medical procedures safer with improved efficiency. I have now been awarded 3 approved US medical device patents and 4 pending. I think it is a great opportunity for all of us to get together to advance the field of medical device development, work on mutual interest to improve patient care, and satisfaction with improved medical device usage. I have attached a copy of the approved US patent for the device.**

Thank you for your consideration and look forward to your review and response.

Anthony G. Stanley, MD

On Tue, Jan 18, 2022 at 5:51 PM Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)> wrote:

Dr. Stanley,

Please note that since this is a purchasing issue, and not a potential co-development opportunity, it is no longer in the hands of Innovations, and will be passed to those who will be able to adequately evaluate your new designs.

Best,

Nila

---

**From:** Stephanie Parra <[Stephanie.Parra@baptisthealth.net](mailto:Stephanie.Parra@baptisthealth.net)>  
**Sent:** Tuesday, January 18, 2022 5:36 PM  
**To:** [stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)  
**Cc:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>; Lisa Gordon <[lisag@baptisthealth.net](mailto:lisag@baptisthealth.net)>  
**Subject:** RE: [External]

Good afternoon Dr. Stanley,



I hope this email finds you well.

We received your voicemail earlier today and have elevated your request to our Miami Cardiac & Vascular Institute team. Lisa Gordon will be reaching out to you soon to discuss the next steps and getting a meeting scheduled.

Thank you.

Best regards,

**Stephanie Parra**

Innovation Project Manager

Baptist Health Innovations

**Baptist Health South Florida**

6855 S. Red Rd. | Coral Gables, FL 33143

Direct: (786) 662-7859

[Stephanie.Parra@baptisthealth.net](mailto:Stephanie.Parra@baptisthealth.net) | Baptist Health Innovations

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**From:** Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>

**Sent:** Monday, December 27, 2021 7:37 AM  
**To:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Cc:** Bill M. Duquette <[BillD@baptisthealth.net](mailto:BillD@baptisthealth.net)>; Stephanie Parra <[Stephanie.Parra@baptisthealth.net](mailto:Stephanie.Parra@baptisthealth.net)>; Carla Garic <[carla.garic@wellspring.com](mailto:carla.garic@wellspring.com)>; Barry Katzen <[BARRYK@baptisthealth.net](mailto:BARRYK@baptisthealth.net)>  
**Subject:** Re: [External]

12/26/2021

Dear Baptist Health of South Florida Innovations:

I am contacting your department to introduce a new cutting device that I have invented. The device was actually presented in its prototype stage at the Baptist Doral Plaza to a group of BOS representatives, it was tested for functionality and well received. That meeting was held on June 5<sup>th</sup>, 2018. The device is now fully developed and has a **United States Patent** (see attached). The first shipment is now in Ohio being packaged and will be **FDA Registered and Device Listed** as required as a **Class 1 Medical Device** in late January, 2022, before shipping to Miami, Florida. It is my desire and intent to have **Baptist Health of South Florida**, to have the first opportunity to purchase and partner with my group. I think this is a unique opportunity to have **your own in-house staff member** that is an **inventor, first responder in your urgent care system** and **born and raised in the South Florida Community**. I think that concept will go over well with the local community. The device is designed to replace many of the surgical wire cutters currently used due to its improved safety designs and features. The cutter can be used in **Orthopedic Surgery, Cardiac Surgery, Podiatry Surgery, Emergency Room and in the Urgent Care Centers**. It is one of the best surgical wire cutters on the market. The device last week was approved for patenting in Europe, so you know it must work well. The device is called a "Moby Cutter" and is 7 years now in the making.

Over the past 7 years with my background in healthcare and mechanical engineering science, I conducted research on the functionality of multiple commercial and surgical wire cutters while designing the current one whose pictures were previously sent to the Innovations Department. In conjunction with the design, I wrote an article (**An Urgent Care Approach to Fishhook Removal**) on June 1, 2021 in the **Journal of Urgent Care Medicine**. The article was written by myself and co-authored by one of the Baptist Health of South Florida's Premier Infectious Disease physicians, Dr. **Jorge Murillo**, however the **timely article** was **misprinted** (see below acknowledgement by the JUCM) and a reprint is not available at this time to assist your committee to understand the need for the wire cutter and its purchase.



It has been brought to our attention that the publication titled "An Urgent Care Approach to Fishhook Removal" originally published in June 2021 digital edition of The Journal of Urgent Care Medicine on June 1, 2021 ("Publication"), contains several changes made during the editing process performed by JUCM which the authors took issue with and subsequently demanded the Publication be retracted. Accordingly, at the request of the authors, Anthony G. Stanley, MD and Jorge Murillo, MD, we have fully retracted the Publication.

[An Urgent Care Approach to Fishhook Removal - Journal of Urgent Care Medicine \(jucm.com\)](http://jucm.com)

However, I have developed a **powerpoint presentation** to help compensate for the loss of the article and ask your committee to allow me to come in for a formal presentation and hands on demonstration with your purchasing department and appropriate clinical representatives. As your surgeon reviewer said in your last email to me, it was **hard for him to understand the application by looking at pictures**, ... *"and if it works properly, it may add safety in the OR"*. I believe a formal presentation to the key committee members will quickly show the potential of the device and the timely ness of its arrival to Baptist Health OF South Florida. Some of you may know or have heard of me, I have been working with Baptist Health of South Florida since completing Internal Medicine Residency at Jackson Memorial Hospital in 1997. I have worked at Homestead Hospital for many years and currently registered Baptist Medical Staff working in the BOS Urgent Care

hospital for many years and currently registered Baptist medical staff working in the EOC urgent care facilities.

I appreciate your review of my introduction and look forward to setting up a formal meeting to have a chance to properly introduce my surgical device with multiple applications.

Sincerely,

Anthony G. Stanley, MD

On Fri, Dec 17, 2021 at 8:23 AM Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)> wrote:

Dr. Stanley,

Your information was shown to a surgeon in our system, and this was the reply.

*"I think the concept is a good one, I'm not sure I understand how it actually works by looking at the design or pictures of the device. Certainly we have all seen flying pieces of wire after clipping them, and if it works properly it may aid safety in the OR."*

Best,

Nila

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**From:** Anthony Stanley MD <[stanmeddesigns@gmail.com](mailto:stanmeddesigns@gmail.com)>  
**Sent:** Thursday, December 16, 2021 1:48 PM  
**To:** Nila D. Bhakuni <[NilaB@baptisthealth.net](mailto:NilaB@baptisthealth.net)>  
**Cc:** Bill M. Duquette <[BillD@baptisthealth.net](mailto:BillD@baptisthealth.net)>  
**Subject:** [External]

**\*External Email: Exercise Caution!**

Hello Nila:

I have not heard from anyone regarding my medical device review since your communication on October 13, 2021.

I am just contacting you to follow up on the next steps.

Thanks

Anthony G. Stannley, MD

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**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT P  
TO COMPLAINT FILED  
FEBRUARY 28, 2023

Stanley, Anthony

*Scheduled 13 12 Hrs Shifts FOR*

Shift Search

Click on drop down to Search->

May - 2021

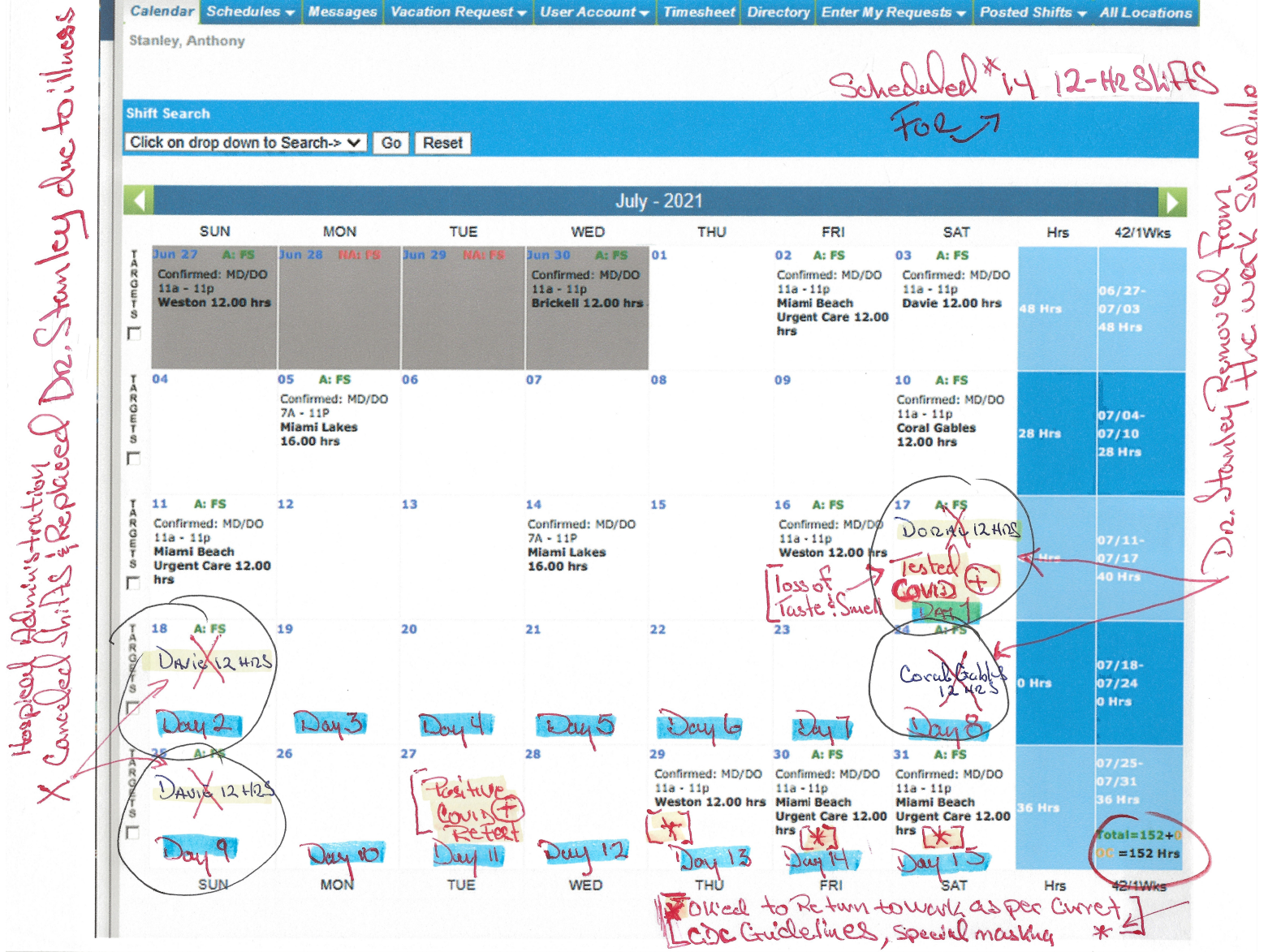
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
TARGETS	<b>Apr 25 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>Apr 26 NA: FS</b>	<b>Apr 27 NA: FS</b>	<b>Apr 28 NA: FS</b> Confirmed: MD/DO 11a - 11p Weston 12.00 hrs	<b>Apr 29 NA: FS</b>	<b>Apr 30 A: FS</b> Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	<b>01 A: FS</b> Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	48 Hrs	04/25-05/01 48 Hrs
TARGETS	<b>02 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>03 NA: FS</b>	<b>04 NA: FS</b>	<b>05 NA: FS</b>	<b>06 NA: FS</b>	<b>07 NA: FS</b>	<b>08 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	24 Hrs	05/02-05/08 24 Hrs
TARGETS	<b>09 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>10 NA: FS</b>	<b>11 NA: FS</b>	<b>12 NA: FS</b>	<b>13 NA: FS</b>	<b>14 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>15 A: FS</b> Confirmed: MD/DO 11a - 11p University 12.00 hrs	36 Hrs	05/09-05/15 36 Hrs
TARGETS	<b>16 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>17 NA: FS</b>	<b>18 NA: FS</b>	<b>19 NA: FS</b>	<b>20 NA: FS</b>	<b>21 NA: FS</b> Confirmed: MD/DO 11a - 5p Weston 6.00 hrs	<b>22 A: FS</b> Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	30 Hrs	05/16-05/22 30 Hrs
TARGETS	<b>23 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>24 NA: FS</b>	<b>25 NA: FS</b>	<b>26 NA: FS</b>	<b>27 NA: FS</b>	<b>28 NA: FS</b>	<b>29 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	24 Hrs	05/23-05/29 24 Hrs
TARGETS	<b>30 A: FS</b> Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	<b>31 A: FS</b> Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	<b>Jun 01 NA: FS</b>	<b>Jun 02 NA: FS</b>	<b>Jun 03 NA: FS</b>	<b>Jun 04 NA: FS</b>	<b>Jun 05 A: FS</b> Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	36 Hrs	05/30-06/05 36 Hrs Total=198+0 00=198 Hrs
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks

Type here to search



<a href="#">Calendar</a> <a href="#">Schedules</a> <a href="#">Messages</a> <a href="#">Vacation Request</a> <a href="#">User Account</a> <a href="#">Timesheet</a> <a href="#">Directory</a> <a href="#">Enter My Requests</a> <a href="#">Posted Shifts</a> <a href="#">All Locations</a>									
Stanley, Anthony									
<div>Shift Search</div> <div>Click on drop down to Search-&gt; <input type="button" value="Go"/> <input type="button" value="Reset"/></div>									
June - 2021									
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
TARGETS	May 30 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	May 31 A: FS Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	01 NA: FS	02 NA: FS	03 NA: FS	04 NA: FS	05 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	36 Hrs	05/30-06/05 36 Hrs
TARGETS	06 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	07 NA: FS	08 NA: FS	09 NA: FS	10 NA: FS	11 A: FS Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	12 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	36 Hrs	06/06-06/12 36 Hrs
TARGETS	13 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	14 NA: FS	15 NA: FS	16 NA: FS	17 NA: FS	18 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	19 A: FS Confirmed: MD/DO 11a - 11p Sawgrass 12.00 hrs Note: Weston to remote for this site	36 Hrs	06/13-06/19 36 Hrs
TARGETS	20 A: FS Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	21 NA: FS	22 NA: FS	23 NA: FS	24 NA: FS	25 A: FS Confirmed: MD/DO 11a - 11p Sawgrass 12.00 hrs	26 A: FS Confirmed: MD/DO 11a - 11p Sawgrass 12.00 hrs Note: University to remote for this site	36 Hrs	06/20-06/26 36 Hrs
TARGETS	27 A: FS Confirmed: MD/DO 11a - 11p Weston 12.00 hrs	28 NA: FS	29 NA: FS	30 A: FS Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	Jul 01	Jul 02 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	Jul 03 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	48 Hrs	06/27-07/03 48 Hrs
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
								Total=192+0 00 =192 Hrs	

Schedule # 12 12 Hr Shifts  
For





Scheduled \* 20 12 HR Shifts  
For →

[Publish Report](#)

Shift Search

Click on drop down to Search->

August - 2021

	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
01 NA: FS	02 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs [*]	03 A: FS	04 A: FS	05 Retest Confirmed: MD/DO 11a - 11p Davie 12.00 hrs [*] Could Day 20	06 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	07 A: FS	08 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	48 Hrs	08/01-08/07 48 Hrs
08 A: FS	09 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	10	11 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	12	13	14 A: FS	15 Confirmed: MD/DO 9A - 9P Plantation 12.00 hrs Note: Sawgrass to remote for this site	36 Hrs	08/08-08/14 36 Hrs
15 A: FS	16 Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	17 Confirmed: MD/DO 9A - 11A Miami Lakes 2.00 hrs Confirmed: MD/DO 11A - 430P Davie 5.50 hrs Confirmed: MD/DO 5P - 9P Weston 4.00 hrs	18 Confirmed: MD/DO 9a - 9p CCPP 12.00 hrs	19	20 Confirmed: MD/DO 11a - 7p Coral Gables 8.00 hrs	21 A: FS	22 Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	55.5 Hrs	08/15-08/21 55.5 Hrs
22 A: FS	23 Confirmed: MD/DO 11a - 11p University 12.00 hrs	24 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	25	26	27 Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	28 A: FS	29 Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	48 Hrs	08/22-08/28 48 Hrs
29 A: FS	30 Confirmed: MD/DO 9A - 9P Miami Lakes 12.00 hrs	31 A: FS	Sep 01 Txt for av. B 10:21 - YC	Sep 02	Sep 03	Sep 04 A: FS	Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	36 Hrs	08/29-09/04 36 Hrs
								Total=223.5+0 00 =223.5 Hrs	
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks

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Calendar Schedules Messages Vacation Request User Account Timesheet Directory Enter My Requests Posted Shifts All Locations

Stanley, Anthony

*Schedule #12 12 Hrs Shifts*

Shift Search

Click on drop down to Search-> Go Reset

September - 2021

	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
TARGETS	Aug 29 A: FS Confirmed: MD/DO 9A - 9P Miami Lakes 12.00 hrs	Aug 30	Aug 31 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	01 Txt for av. 8.10.21 - YC	02	03	04 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	36 Hrs	08/29-09/04 36 Hrs
TARGETS	05 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	06	07	08	09 A: FS	10	11 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	24 Hrs	09/05-09/11 24 Hrs
TARGETS	12 A: FS	13 Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	14	15	16 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	17	18 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	36 Hrs	09/12-09/18 36 Hrs
TARGETS	19 A: FS Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	20	21 Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	22	23	24 Confirmed: MD/DO 5P - 11P University 6.00 hrs	25 A: FS Confirmed: MD/DO 11a - 11p Coral Gables 12.00 hrs	42 Hrs	09/19-09/25 42 Hrs
TARGETS	26 A: FS Confirmed: MD/DO 11a - 11p Brickell 12.00 hrs	27	28	29 Confirmed: MD/DO 11a - 11p Davie 12.00 hrs	30	Oct 01 A: FS	Oct 02 A: FS Confirmed: MD/DO 11a - 11p Miami Beach Urgent Care 12.00 hrs	36 Hrs	09/26-10/02 36 Hrs
	SUN	MON	TUE	WED	THU	FRI	SAT	Hrs	42/1Wks
									Total=174+0 00 =174 Hrs

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**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT Q  
TO COMPLAINT FILED  
FEBRUARY 28, 2023



[ "Covid Positive For 20 Days" ]

# Baptist Health South Florida

## COVID Center

STANLEY, ANTHONY G

Birth Date: Mar 24, 1957

### COVID-19 Immunizations

No information recorded

### COVID-19 Laboratory Results

#### SARS-CoV-2 (COVID-19)

**Negative**

Collection Date: Aug 05, 2021 10:18 a.m. EDT Reference Range: Negative

Ordered By: Carriazo Isasi, Jorge MD

Note: Aug 05, 2021 10:37 a.m. EDT

Coronavirus Interpretation

Negative: Negative results should be treated as presumptive and, if inconsistent with clinical signs and symptoms or necessary for patient management, should be tested with an alternative molecular assay.

This result does not rule out co-infection with other pathogens.

Positive: COVID-19 viral RNA detected.

Invalid: The presence or absence of COVID-19 Viral RNA cannot be determined. Please consider re-collection of a new specimen, if clinically indicated.

NOTE: This is a molecular test utilizing isothermal nucleic acid amplification for the qualitative detection of nucleic acid from the SARS-CoV-2 viral RNA in patient samples. The test has not been FDA approved or cleared. This test is authorized for use under the Food and Drug Administration's Emergency Use Authorization (EUA).

#### SARS-CoV-2 (COVID-19)

**NOT DETECTED**

Collection Date: Aug 05, 2021 10:18 a.m. EDT Reference Range: NOT DETECTED

Ordered By: Carriazo Isasi, Jorge MD

**Note:** Aug 06, 2021 03:40 p.m. EDT

A Not Detected (negative) test result for this test means that SARS- CoV-2 RNA was not present in the specimen above the limit of detection. A negative result does not rule out the possibility of COVID-19 and should not be used as the sole basis for treatment or patient management decisions. If COVID-19 is still suspected, based on exposure history together with other clinical findings, re-testing should be considered in consultation with public health authorities. Laboratory test results should always be considered in the context of clinical observations and epidemiological data in making a final diagnosis and patient management decisions. Please review the "Fact Sheets" and FDA authorized labeling available for health care providers and patients using the following websites: <https://www.questdiagnostics.com/home/Covid-19/HCP/QuestIVD/fact-sheet.html> <https://www.questdiagnostics.com/home/Covid-19/Patients/QuestIVD/fact-sheet.html> This test has been authorized by the FDA under an Emergency Use Authorization (EUA) for use by authorized laboratories. Due to the current public health emergency, Quest Diagnostics is receiving a high volume of samples from a wide variety of swabs and media for COVID-19 testing. In order to serve patients during this public health crisis, samples from appropriate clinical sources are being tested. Negative test results derived from specimens received in non-commercially manufactured viral collection and transport media, or in media and sample collection kits not yet authorized by FDA for COVID-19 testing should be cautiously evaluated and the patient potentially subjected to extra precautions such as additional clinical monitoring, including collection of an additional specimen. Methodology: Nucleic Acid Amplification Test (NAAT) includes RT-PCR or TMA Additional information about COVID-19 can be found at the Quest Diagnostics website: [www.QuestDiagnostics.com/Covid19](http://www.QuestDiagnostics.com/Covid19). Lab test performed by: Lab Mnemonic: MI Quest Diagnostics-Miami 10200 Commerce Pkwy Miramar, FL 33025-3938 DR. Julie L Friedman

### **SARS-CoV-2 (COVID-19)**

**Positive (Critical)**

Collection Date: Jul 27, 2021 10:42 a.m. EDT

Reference Range: Negative

**Ordered By:** Carriazo Isasi, Jorge MD

**Note:** Jul 27, 2021 10:53 a.m. EDT

Critical results called to DR.Carriazo at 07/27/2021 10:53:42 EDT by AP. Read back and verified? YES

**Note:** Jul 27, 2021 10:53 a.m. EDT

Coronavirus Interpretation

Negative: Negative results should be treated as presumptive and, if inconsistent with clinical signs and symptoms or necessary for patient management, should be tested with an alternative molecular assay.

This result does not rule out co-infection with other pathogens.

Positive: COVID-19 viral RNA detected.

Invalid: The presence or absence of COVID-19 Viral RNA cannot be determined. Please consider re-collection of a new specimen, if clinically indicated.

NOTE: This is a molecular test utilizing isothermal nucleic acid amplification for the qualitative detection of nucleic acid from the SARS-CoV-2 viral RNA in patient samples. The test has not



been FDA approved or cleared. This test is authorized for use under the Food and Drug Administration's Emergency Use Authorization (EUA).

### **SARS-CoV-2 (COVID-19)**

### **NOT DETECTED**

Collection Date: Jul 27, 2021 10:42 a.m. EDT      Reference Range: NOT DETECTED

**Ordered By:** Carriazo Isasi, Jorge MD

**Note:** Jul 28, 2021 09:00 p.m. EDT

A Not Detected (negative) test result for this test means that SARS- CoV-2 RNA was not present in the specimen above the limit of detection. A negative result does not rule out the possibility of COVID-19 and should not be used as the sole basis for treatment or patient management decisions. If COVID-19 is still suspected, based on exposure history together with other clinical findings, re-testing should be considered in consultation with public health authorities. Laboratory test results should always be considered in the context of clinical observations and epidemiological data in making a final diagnosis and patient management decisions. Please review the "Fact Sheets" and FDA authorized labeling available for health care providers and patients using the following websites: <https://www.questdiagnostics.com/home/Covid-19/HCP/QuestIVD/fact-sheet.html> <https://www.questdiagnostics.com/home/Covid-19/Patients/QuestIVD/fact-sheet.html> This test has been authorized by the FDA under an Emergency Use Authorization (EUA) for use by authorized laboratories. Due to the current public health emergency, Quest Diagnostics is receiving a high volume of samples from a wide variety of swabs and media for COVID-19 testing. In order to serve patients during this public health crisis, samples from appropriate clinical sources are being tested. Negative test results derived from specimens received in non-commercially manufactured viral collection and transport media, or in media and sample collection kits not yet authorized by FDA for COVID-19 testing should be cautiously evaluated and the patient potentially subjected to extra precautions such as additional clinical monitoring, including collection of an additional specimen. Methodology: Nucleic Acid Amplification Test (NAAT) includes RT-PCR or TMA Additional information about COVID-19 can be found at the Quest Diagnostics website: [www.QuestDiagnostics.com/Covid19](http://www.QuestDiagnostics.com/Covid19). Lab test performed by: Lab Mnemonic: MI Quest Diagnostics-Miami 10200 Commerce Pkwy Miramar, FL 33025-3938 DR. Julie L Friedman

### **SARS-CoV-2 (COVID-19)**

**Positive (Critical)**

Collection Date: Jul 17, 2021 09:44 a.m. EDT      Reference Range: Negative

**Ordered By:** Perugorria, Yamirka MD

**Note:** Jul 17, 2021 09:54 a.m. EDT

Critical results called to Dr.Perugorria at 07/17/2021 09:54:36 EDT by AP. Read back and verified? yes

**Note:** Jul 17, 2021 09:54 a.m. EDT

Coronavirus Interpretation

Negative: Negative results should be treated as presumptive and, if inconsistent with clinical signs and symptoms or necessary for patient management, should be tested with an alternative

**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT R  
TO COMPLAINT FILED  
FEBRUARY 28, 2023



Website: [www.ChaseLawyers.com](http://www.ChaseLawyers.com)

IP, Entertainment, Arts, Sports and Media Law

21 SE 1 <sup>st</sup> Ave. Suite 700 Miami, FL 33131 USA Office (305) 373-7665 Fax (305) 373-7668	1345 6th Avenue, 2nd floor, New York, NY 10105 Office (212)-601-2762 Fax (305) 373-7668
--	--

Barry Oliver Chase  
Senior Partner  
[Barry@ChaseLawyers.com](mailto:Barry@ChaseLawyers.com)  
Florida, New York, District of  
Columbia, US Supreme Court

Gregory Bloom  
Partner  
[Greg@ChaseLawyers.com](mailto:Greg@ChaseLawyers.com)  
Florida

Alexander Loveyko  
Associate Attorney  
[Alex@ChaseLawyers.com](mailto:Alex@ChaseLawyers.com)  
New York

Anastasia Latman  
Associate Attorney  
[Anastasia@ChaseLawyers.com](mailto:Anastasia@ChaseLawyers.com)  
New York

September 23, 2021

**To: Braveheart Group LLC d/b/a “The Journal of Urgent Care Medicine”**

**185 State Route 17, Suite 4**

**Mahwah, NJ 07430**

Via email to [swilliams@jucm.com](mailto:swilliams@jucm.com), [editor@jucm.com](mailto:editor@jucm.com)

Dear Mr. Williams,

Reaching out on behalf of our client, Dr. Anthony Stanley (“Client” or “Copyright Owner”), in regard to the article published by your company, The Journal of Urgent Care Medicine (“Publisher”) on June 1, 2021, titled “An Urgent Care Approach to Fishhook Removal” with a URL located at <https://www.jucm.com/documents/jucm-June-2021.pdf> (“Publication”), as well as printed in the June 2021 print edition of the Publisher.

We have been informed by our Client, and have concluded from independently researching the matter at hand, that there were several substantial infringements of our client’s rights, both as it regards federal copyright legislation, as well as local legislation on defamation by Publisher as follows:

**I. Violation of our Client’s rights under the Copyright Act.**

In your email dated June 23, 2021, addressed to our Client you are referring to an approval allegedly received from our Client on May 5<sup>th</sup>, 2021 in regard to the version of the Original Article that was to be published in the Publication (“Approval Correspondence”). See Exhibit A for the copy of that correspondence and a copy of the June 23 correspondence.

Please also see Exhibit B, comparing the version approved by our Client in Approval Correspondence and the version of the Original Article actually published in the Publication (online version), and identifying the parts of Publication inserted or removed without Dr. Stanley’s approval, as well as the legend of existing typos, misrepresentations, improper attributions of rights ownership and basic spelling mistakes currently present in the Publication.

Description of differences:

1. Section “Urgent Message” added w/o our Client’s approval.



2. Photo by “Thundermist Lure Company” removed w/o our Client’s approval.
3. The following sentences added w/o our Client’s approval:

“U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center.”

“From this author’s experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there’s a fishhook injury in the waiting room.”

4. Photo by Dr. Stanley was removed w/o our Client’s approval, and, moreover, in contradiction with a direct request by Dr. Stanley in an email dated 06/05/2021.
5. Five (5) Photos removed from the “Trauma Gallery” section of the Original Article w/o our Client’s approval.
6. Photo by “Ty Southerland” removed w/o our Client’s approval.
7. An answer to the question posed by Publisher to Dr. Stanley under a premise of peer review during the approval process was reworded, supplemented with Publisher’s own comments and published w/o our Client’s approval.

Additionally, the following violations were performed by Publisher in its printed version of the Publication (please see Exhibit C detailing the placement of the violations attached to herein):

1. Unauthorized use of a photo belonging to by Dr. Stanley in violation of his rights.
2. Misplaced photos (Figure 5, Figure 6, Figure 7, Figure 9, Figure 10) confusing the reader and leading to potential injuries to the reading public.

As is evident from both Exhibit B, Exhibit C, the legend of existing mistakes and misrepresentations (in Exhibit B) and the breakdown provided above, the version originally approved for publication by Dr. Stanley on May 5<sup>th</sup>, as referred to above, and in your correspondence dated June 23, 2021, is substantially different from the version actually published in the Publication (including the print version) violating a number of rights of our Client under the Copyright Act (please see below).

Please be aware, that our Client has performed a filing for Copyright Registration in regard to the original version of the Publication (“Original Article”), Copyright Claim # 1-10640834731 on 07/08/2021 – within three (3) months of the work’s publication as per 17 U.S.C. 412 - providing himself with access to both actual and statutory damages associated with the infringement of the scope of his rights under the Copyright Act.

Publisher’s failure to obtain our Client’s authorization to publish the Publication violated Dr. Stanley’s rights to distribute the Original Article, to publicly display the Original Article, and to prepare derivative works on the basis of the Original Article, with the Publisher going beyond the scope of any implied license by implementing edits and amendments that were both contrary to the spirit of the Original Article, as well as potentially harmful to both our Client’s reputation and health of the public.

Namely, in present instance, registration of Dr. Stanley's rights to the Original Article and subsequent violation of his rights under the Copyright Act by the Publisher, results in potential liability for copyright infringement for the Publisher, the scope of statutory damages for which can be as high as **\$150,000 (One Hundred and Fifty Thousand US Dollars)** per work infringing, as per 17 U.S.C. 504, as well as attorney's fees.

Copyright Owner treats copyright infringement as a very serious matter and fully enforces its rights against infringers. Under the circumstances, Copyright Owner is prepared to try to resolve this matter amicably provided that you cooperate fully with Copyright Owner and establish to its satisfaction that this was a one-time error of judgment and not a systematic effort to profit from Copyright Owner's intellectual property.

## **II. Claim of Defamation under Florida Law**

Under Florida law, the elements of a defamation claim are:

- the defendant published a false statement;
- about the plaintiff;
- to a third party; and
- the falsity of the statement caused injury to the plaintiff.

*Border Collie Rescue v. Ryan*, 418 F.Supp.2d 1330, 1348 (M.D.Fla. 2006). A plaintiff must also prove that the defendant's fault in publishing the statement amounted to at least negligence.

In present instance, all elements are clearly evident from the facts of the case:

- 1) Publisher published the Publication that contains multiple inconsistencies, medical inaccuracies and potentially harmful recommendations to the readers of the Publication;
- 2) Publisher identified Dr. Stanley as the author of the Publication, leading to reputational damages to Dr. Stanley, as well as potentially negligent infliction of harm to the public at large;
- 3) Publisher distributed the Publication to third parties via providing access to the Publication at the <https://www.jucm.com/documents/jucm-June-2021.pdf/> URL as well as in the printed version of the Publication;
- 4) Publisher have caused and continues to cause substantial reputational damages to our Client by refusing to retract or edit the Publication, in violation of our Client's rights.

Please see Exhibit D for a Petition for Article Retraction ("Retraction Statement") authored by William Kranichfeld, MD, Ernesto Sanz, MD, Betty Ruiz, ARNP, Dia Nguyen, MD, Yenny Ceballos, ARNP, Anisleydi Pardon, ARNP, Michael Sasoni, MD and Bonnie J. O'Sullivan, MD that identifies the following issues existing with the publication:

- 1) Factual and grammatical errors
- 2) Factual misrepresentations and omissions
- 3) Unauthorized and incorrect medical advice provided by Publisher under Dr. Stanley's name

Our Client fully intends to proceed with asserting his claims of defamation, if the Publisher fails to comply with our

respectful demands contained below, due to the contents of Publication being harmful not only as it pertains his personal reputation, but also potentially, subject to a tort of negligence, due to the Publication reflecting a breach on behalf of the Publisher, as a medical issue, of its duty to provide correct and truthful information to the medical professionals that can use this information to serve the public, as confirmed by a number of medical professionals that have authored the Petition Statement.

Failure of Publisher to comply with our respectful demands contained in the later section will result in our Client asserting the claim of defamation under Florida law, subject to compensatory, punitive and other available damages under the appropriate legislation.

### **III. Provisions of Florida's Retraction Statute**

Under the Florida retraction statute, Fla. Stat. § 770.02, once the publisher receives the retraction request, the publisher must **publish the correction, apology, or retraction within:**

- ten days of notice, for a daily or weekly publication;
- twenty days of notice, for a semimonthly publication;
- forty-five days of notice, for a monthly publication; or
- the next issue, for a work published "less frequently than monthly," as long as the plaintiff serves the notice no later than 45 days prior to such publication.

The publisher must make a **full and fair correction, apology, or retraction** by placing it in the same editions or corresponding issues of the newspaper or periodical in which said article appeared and in as conspicuous place and type as said original article.

Failure of the Publisher to retract an offensive publication may result in the plaintiff potentially claiming not only actual damages resulting from the defamation inflicted by the improper publication, but also reputational or punitive damages.

### **IV. Our Respectful Demands**

Our Client fully intends to assert his rights under both federal Copyright legislation, as well as local civil regulations pertaining to defamation, and negligence on behalf of the Publisher in publishing an unauthorized version of the Original Article at the <https://www.jucm.com/documents/jucm-June-2021.pdf> URL, unless:

1. Publisher immediately ceases and desists from all further attempts to reproduce, publish, provide, distribute, transmit, display, publicly perform, or otherwise make any use of the Publication as it is currently published at the <https://www.jucm.com/documents/jucm-June-2021.pdf> URL.
2. Publisher immediately ceases and desists from all further attempts to reproduce, publish, provide, distribute, transmit, display, publicly perform, or otherwise make any use of the Publication as it is currently published in its printed June 2021 version.

3. Publisher interprets this Demand Letter as the “retraction request” within the meaning of Fla. Stat. § 770.02.
4. In accordance with Fla. Stat. § 770.02, as well as the Publisher’s own Retraction Rules which can be found at <https://www.jucm.com/author-instructions/>, under “Retractions”, Publisher makes a **full and fair apology, or retraction** by placing it in the same edition or issue of the newspaper or periodical in which said article appeared and in as conspicuous place and type as said original article (both online and printed versions).
5. Publisher makes a correction, by publishing an updated version of the Original Article attached to herein as Exhibit E, by placing it in the same edition or issue of the newspaper or periodical in which said article appeared and in as conspicuous place and type as said original article (both online and printed versions), as the current Publication contains flawed or erroneous data such that its findings and conclusions cannot be relied upon.

**The above does not constitute a full recitation of our Client's rights or claims and nothing set forth herein constitutes a waiver of any of our Client's rights, remedies and positions, all of which are expressly reserved.**

Please contact the undersigned no later than **five (5) days** from the date of this letter to confirm that the parties are in mutual understanding that the absence of action on behalf of the Publisher will result in us advising our Client to consider legal action to enforce his rights and to collect the damages for defamation as well as an action for copyright infringement under the Copyright Act, subject to the claims for actual, statutory damages and attorney’s fees.

**Name:** Alexander Loveyko, Esq.

**Address:** 21 SE 1<sup>st</sup> Ave, Suite 700,  
Miami, FL, USA 33131

**Telephone:** 305-373-7665

**Email:** [alex@chaselawyers.com](mailto:alex@chaselawyers.com)

Very truly yours,

A handwritten signature in blue ink that reads "Loveyko Alexander". The signature is written in a cursive, flowing style.

Attorney of Record for Client

**Exhibit A – “Correspondence Printouts”**

Emails From **Scholastica** Web Portal

Total (4)

## Clinical Approach to Fishhook Removal

Submitted on Feb 16, 2021 - Manuscript ID: 1320812

Start a discussion

- Anthony G. Stanley

Jun 4, 2021 - 11:11 am EDT

Article Credits

4

Hello Harris ; Dr. Murillo's name is spelled wrong can we make correction on some of the online d...

- Anthony G. Stanley

May 17, 2021 - 2:43 pm EDT

Receipt of your submission to JUCM

8

Ok great Harris. Looking forward to reading it along with family and friends. Yes please send a f...

- Anthony G. Stanley

Apr 29, 2021 - 11:41 am EDT

Article discussion and photos

4

Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...

Discussion with *Journal of Urgent Care Medicine*

## Article discussion and photos

- Anthony G. Stanley

Apr 16, 2021 - 7:32 pm EDT

Hello Harris: I would like to contact you on Monday to discuss some aspects of the article and set up. I will try to contact you Monday 4/19/21 after 10:30am, if it is good timing for you.

Dr. Stanley

- Anthony G. Stanley

Apr 19, 2021 - 10:44 am EDT

hello

Attachments

- work copy an urgent care approach to fishhook removal

- Anthony G. Stanley

Help



Apr 20, 2021 - 7:26 am EDT

Hello Harris:

I contacted all the photo copyright owners and cc you last evening. Attached is a composite contact list.

keep me posted.

Dr. Stanley

Attachments

- 2021 copy right granted list a autorecovered .docx
- Anthony G. Stanley

Apr 29, 2021 - 11:41 am EDT

Hello Harris:

Just checking to see how the project is coming along. Let if you need my assistance.

Take

Dr. Stanley

## Post a response

**bolditalicbulletsnumberslink**

Add an attachment

Choose File

No file chosen

Add file

## Allowed file types

**You may upload the following types of files:**

\*.aac, \*.avi, \*.csv, \*.doc, \*.docx, \*.flac, \*.gif, \*.html, \*.jpeg, \*.jpg, \*.key, \*.m4a, \*.md, \*.mov, \*.mp3, \*.mp4, \*.mpeg, \*.mpg, \*.odt, \*.pdf, \*.png, \*.pps, \*.ppt, \*.tex, \*.tif, \*.tiff, \*.txt, \*.xls, \*.xml, \*.zip

If you have a file that is unsupported please archive it within a **\*.ZIP** file before uploading.

Post Message

X

Email From Scholastic Web Portal

Total 8

## Clinical Approach to Fishhook Removal

Submitted on Feb 16, 2021 - Manuscript ID: 1320812

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Apr 29, 2021 - 11:41 am EDT

Article discussion and photos

4

Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...

Discussion with *Journal of Urgent Care Medicine*

## Receipt of your submission to JUCM

- Harris Fleming

Feb 17, 2021 - 8:02 am EST

Dear Dr. Stanley,

Thank you for submitting your manuscript to *JUCM, The Journal of Urgent Care Medicine*. We appreciate your taking the time and the initiative to contribute to the growing body of urgent care literature.

Your article will be shared with a member of our clinical editorial team, after which I will update you on its status. You can expect to hear from me in 2 to 4 weeks. Typically, manuscripts that are accepted by our journal will to 6 months after submission, depending on seasonality, the peer and other factors.

Help

13



If you have any questions at any time, please email me at hfleming@jucm.com.

Thanks again.

Harris

**Harris Fleming**  
**Executive Editor**  
***JUCM, The Journal of Urgent Care Medicine***

- Anthony G. Stanley  
Mar 2, 2021 - 8:54 am EST  
Hello Harris: Just checking in. This is my first journal article. Let me know if you need any information from me, medical illustrations, photos etc...  
  
Have a great day!  
Dr. Stanley
- Harris Fleming  
Apr 30, 2021 - 12:01 pm EDT  
Dr. Stanley,  
Right now your manuscript is being read by a couple members of our peer review panel. It's the final step before preparing the article for publication. I will let you know whether or not they have any queries. I've asked them to get back to me no later than today.  
  
Thank you for checking in.  
  
Harris
- Anthony G. Stanley  
May 5, 2021 - 6:31 pm EDT  
Hello Harris: I reviewed the article . I made a few rearrangements of photos to make everything flow a little better. I was able to cut the page count from 13 to 12. Content not changed but truncated to conserve space.  
I included my x ray of the fish hooked finger which has been a inspiration point for me writing this article (PATIENT EVALUATION), hope its no problem. I like your edits of the article and satisfied with the results.

Dr. Stanley

Attachments

- [jucm 0621 clinical fishhook post peer review 2.docx](#)
- [jucm article disclosure form ags.pdf](#)
- Anthony G. Stanley  
May 10, 2021 - 7:57 am EDT  
Good Morning Harris;  
Here are two photos of me to choose from and Disclosure from Dr. Murrilo.  
Have a great week.  
Dr. Stanley

Attachments

- [dr.stanley.jpg](#)
- [dr. stanley.jpg](#)
- [jucm disclosure form3 28 21jm.pdf](#)
- Anthony G. Stanley  
May 17, 2021 - 1:31 pm EDT  
Hello Harris:  
  
Just checking if you know if the article is slated for June or July issue?  
Also please send a copy of the final layout plans ( copy and photos) of the article.

Thanks

Dr. Stanley

- Harris Fleming  
May 17, 2021 - 2:39 pm EDT  
Hi, Dr. Stanley.

Your article will be featured on the cover of the June issue, which goes to press this week. I will be happy to send you a few copies after we've received the excess back from the printer, which will probably be in the second week of June. Unfortunately, we're unable to share the layout in advance of publication. It will be available online starting on June 1.

Harris

- Anthony G. Stanley  
May 17, 2021 - 2:43 pm EDT

Ok great Harris. Looking forward to reading it along with family and friends. Yes please send a few copies when you can!

Have a great week

## Post a response

**bold****italic****bullets****numbers****link**

---

Add an attachment

Choose File

No file chosen

Add file

## Allowed file types

**You may upload the following types of files:**

\*.aac, \*.avi, \*.csv, \*.doc, \*.docx, \*.flac, \*.gif, \*.html, \*.jpeg, \*.jpg, \*.key, \*.m4a, \*.md, \*.mov, \*.mp3, \*.mp4, \*.mpeg, \*.mpg, \*.odt, \*.pdf, \*.png, \*.pps, \*.ppt, \*.tex, \*.tif, \*.tiff, \*.txt, \*.xls, \*.xml, \*.zip

If you have a file that is unsupported please archive it within a **\*.ZIP** file before uploading.

Post Message

X



E-mail From Scholastica Web Portal

June 2021  
Total (4)

## Clinical Approach to Fishhook Removal

Submitted on Feb 16, 2021 - Manuscript ID: 1320812

Start a discussion

- Anthony G. Stanley

Jun 4, 2021 - 11:11 am EDT

Article Credits

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- Anthony G. Stanley

May 17, 2021 - 2:43 pm EDT

Receipt of your submission to JUCM

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- Anthony G. Stanley

Apr 29, 2021 - 11:41 am EDT

Article discussion and photos

4

Hello Harris: Just checking to see how the project is coming along. Let if you need my assistance...

Discussion with *Journal of Urgent Care Medicine*

### Article Credits

- Anthony G. Stanley

Jun 1, 2021 - 12:46 pm EDT

Hello Fleming:

I wanted see if my photo can be added to the On-line version and add me to the Authors Bios Section.

Thanks

Dr. Stanley

Attachments

- dr. stanley.jpg
- post review.docx

- Harris Fleming

Help

Jun 1, 2021 - 11:40 pm EDT

Dr. Stanley,

Yes, your photo and your information will be added when the standalone PDF version of your article is uploaded to the website. There is a lag between publication of the issue and its articles and their addition to the archives, which coincides with updating the author bios.

Thank you for asking (and, again, for your excellent contribution).

Harris

- Anthony G. Stanley

Jun 2, 2021 - 10:53 am EDT

Hi Harris:

Thanks for the info. Oh by the way , I wanted to know if in the future , can you send me any statistical data in regards to the article readership .

How many clicks and that sort of info if it is available?

Just want to gauge where it is on the popularity list over time!

Thanks again.

- Anthony G. Stanley

Jun 4, 2021 - 11:11 am EDT

Hello Harris ; Dr. Murillo's name is spelled wrong can we make correction on some of the online documents?

If possible;

Jorge Murillo

Dr. Stanley

## Post a response

[bolditalicbulletsnumberslink](#)

Add an attachment

Choose File

No file chosen

Add file

## Allowed file types

**You may upload the following types of files:**

\*.aac, \*.avi, \*.csv, \*.doc, \*.docx, \*.flac, \*.gif, \*.html, \*.jpeg, \*.jpg, \*.key, \*.m4a, \*.md, \*.mov, \*.mp3, \*.mp4, \*.mpeg, \*.mpg, \*.odt, \*.pdf, \*.png, \*.pps, \*.ppt, \*.tex, \*.tif, \*.tiff, \*.txt, \*.xls, \*.xml, \*.zip

If you have a file that is unsupported please archive it within a **\*.ZIP** file before uploading.

Post Message

X





Anthony Stanley MD <stanmeddesigns@gmail.com>

---

## Article Retraction Request

3 messages

---

Anthony Stanley MD <stanmeddesigns@gmail.com>

Wed, Jun 23, 2021 at 9:07 AM

To: editor@jucm.com

Cc: swilliams@jucm.com, Harris Fleming <hfleming@jucm.com>

6/23/2021

Dear **Journal of Urgent Care Medicine / Braveheart Group, LLC/ Experity Health:**

You recently printed an unauthorized article on June 1, 2021 in the JUCM, entitled **An Urgent Care Approach to Fishhook Removal** under my name which is not my writings. It is superimposed with editorial comments placed by the JUCM and medical advice injected, not authorized by me. I came to your company with integrity, honesty and fairness. However, I was not treated with the same. I want to know why did you do such a thing? The peer reviews your website advertise, worked as a peer take over and operated under inadequate supervision of the editing and rewriting process. The paper is filled with grammatical errors and omitted steps in medical procedural concepts due to unskillful cutting and pasting. I worked and researched the article contents for **7 years** and it's now in ruins as well as my medical reputation. An opportunity to proof the final article was intentionally taken away from me. Why did you do such a thing? Do you take over from **every author, every month** and **deny all authors final proofing** or did you just, **decided to choose** me? Were your actions, **Racially Motivated** or what was your reason? Was your hastiness due to the old acronym Publish or Perish (ideological thinking). **How can you sleep at night knowing what you have done?**

Key sections of my work were wrongfully discarded. There are sections in the paper that your non doctoral staff contributed, giving **medical advice and misinformation** which may have damaging effects if readers act on **wrongful medical advice in performance of patient care**. Read what your agents wrote into the article and compare it to the original submission in the **Scholastica portal**. I am asking that the article be retracted and my original writings be printed unchanged. I was asked to write your organization and **"simply ask, the Journal of urgent Care Medicine to retract the article and remove it from any form of technological circulation"**. I hold all parties mentioned (and copied in this email) accountable and ask for an internal audit of your activity and participation in this event. I look forward to your response. I am very, very disappointed in the JUCM and what has taken place. I hope we can work together to rectify the issues, prevent harm to the readers acting on misinformation and come to a reasonable solution. Your website talks about integrity, honesty and fairness but as you can see by the treatment shown to me, those claims are not true. All of the **doctors on your JUCM staff have a medical license, and** all took a **"Hippocratic Oath"**, I am sure they realized the importance of retracting the article in all forms and setting the record straight, to protect the public. **At the advice of an attorney, I am sending you this letter to "simply ask"**.

Sincerely

---

swilliams@jucm.com <swilliams@jucm.com>

To: Anthony Stanley MD <stanmeddesigns@gmail.com>

Wed, Jun 23, 2021 at 11:27 AM

Dr. Stanley,



I'm sorry to hear that you weren't happy with our publishing your article.

On May 4<sup>th</sup>, you were sent a version of the manuscript of your article that included edits necessitated after our internal medical review comments, and external peer reviewer comments. You may have forgotten that on May 5<sup>th</sup>, you sent an email to Executive Editor Harris Fleming acknowledging the receipt of the revised manuscript, and replied "I like your edits and am satisfied with your results". Upon receipt of your approval, this exact version of the manuscript was sent to our designer for layout.

I don't understand what the problem is, now that the article has been published. You approved the content, in writing. As our medical staff and peer reviewers have agreed, it is a valuable contribution to the medical literature on an important topic in urgent care medicine.

I see no reason to retract this article.

Best wishes,

Stuart



**Stuart Williams**

Publisher

p: 201-529-4004

[Quoted text hidden]

---

**Anthony Stanley MD** <stanmeddesigns@gmail.com>  
Draft To: swilliams@jucm.com

Wed, Jun 23, 2021 at 12:38 PM

Hello Mr. Williams: This is the first time you have formally entered the picture. Welcome! Please try to keep the facts correct. The version (work copy #2 that was corrected by me and ) I sent to Mr. Harris on May 5th is not the version you printed June 1, 2021 online. There is an old Jamacian saying "out of evil, cometh good". I am sure we both will have a clearer understanding with time. The problem still stands as stated in the previous emails. **By your statements today**, It appears you printed an unauthorized version. Recheck your emails time and date. It seems that all emails go to you or Mr. Harris, do you guys own the JUCM?

Dr. Stanley

[Quoted text hidden]



**Exhibit B – “Online Publication Violations and Legend”**

**Journal of Urgent Care Medicine (JUCM) Error Sheet Legend (Comparison of Approved Article and Published Article)**

1. Mr. Harris Fleming (editor), stated to me, the JUCM readers did not want to see the word **Clinical**, it does not sit well with them, they like something with Urgent Care in it so he removed and changed, my title "Clinical Approach to Fishhook Removal" to **An Urgent Care Approach to Fishhook Removal**. Contrary to his statements he uses the word **Clinical Feature Articles** on their JUCM website.
2. Un authorized photo attached to my article. All of my comparable photos, were omitted. Please refer to original article to appreciate all the changes.
3. My article used for advertisement solicitation and attraction or readers.
4. JUCM propaganda injected into my article without permission to steer (brain wash) readers to their Urgent Care mindset- not authorized
5. There is no national data (CDC tracking) on incidence of injuries going to Urgent Care Centers in the US with fishhook injury. This is **medical misinformation**
6. Grammatical error
7. There is no **U.S. data** on incidence on fishhook injury, the **CDC** does not track that information at this time. This is one of the points, pointed out in the original paper but unknowingly taken out during the rapid takeover of the paper (cut and paste process) by the JUCM. They over looked that point completely.
8. Word tense error
9. Poor wording (bad writing habits)
10. The subject **Fishhook Removal System**, which is a totally new concept to medicine, has no lead-in introduction. The lead in statements were cut out during the rapid cut and past proceeding by the JUMC. Since the JUCM, did not write the paper, the cut and paste confederates did not appreciate the concept.
11. Grammatical error
12. Interjection by the JUCM- not authorized
13. Misspelled word
14. Typo
15. Interjection by the JUMC after cut and pasting
16. Placing unauthorized framing and coloring on © copyrighted art without permission
17. Changing colors on the **fish hook diagram** from black to red on © copyrighted art without permission
18. Reproducing art with poor quality coloring
19. Improper © copyright art work salutation
20. Personal Phrase interjection not authorized
21. Wasted space- The JUMC lied and informed me, they had spacing limitations but avoided formatting in space saving set ups.
22. JUCM propaganda injected into my article without permission to steer (brain wash) readers to their Urgent Care mindset- not authorized
23. Typo
24. Improper © copyright art work salutation
25. Typo
26. Improper © copyright art work salutation

27. Improper © copyright art work salutation
28. Found only on the on-line version. The entire chapter on **Needle Cover Technique** is missing
29. Improper © copyright art work salutation
30. Improper © copyright art work salutation
31. Typo
32. Improper © copyright art work salutation
33. Personal Phrase interjection not authorized
34. This entire paragraph starting with “**On first glance.....etc.**”, was written by Mr. Harris Fleming whom in **not a medical doctor** and clearly **giving medical advice** in my article. No permission given.
35. Major error due to not proof reading the on-line version has the **Advance and Cut** section printed twice.
36. POSTREOVAL WOUND CARE, post-removal is spelled wrong

This is my last response to JUCM.  
Response sent to JUCM 6/5/21 approx 6:31 pm  
there is also an email sent.

#### JUCM 0621 Clinical – Fishhook Removal CME

##### An Urgent Care Approach to Fishhook Removal

**Urgent message:** While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

Anthony G. Stanley, MD and Jorge Murrilo, MD

#### INTRODUCTION

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known (or “angling”). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.<sup>1</sup> What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as *collateral damage*.

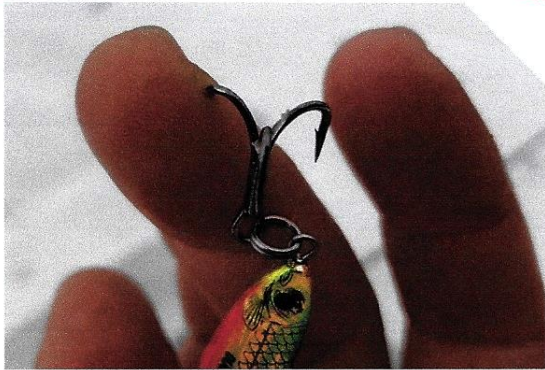


Photo courtesy of Thundermist Lure Company.

U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center. (The emergency department is the site for 28% of all acute care visits in the United States.<sup>2</sup>) From this author's experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there's a fishhook injury in the waiting room.

JUCM  
Comments

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by  
JUCM

JUCM  
Comments



Fishhook removal is a procedure comparable in difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile device similar to the standard suture tray. Here, we review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal and injury management. To do so, it is essential to understand the anatomy of the fishhook, the injured area, and common techniques used to remove fishhooks in a timely and safe manner with minimal trauma.

#### ANATOMY OF THE FISHHOOK—AND WHY IT MATTERS

The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be assessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the “eye” connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The “point” is the sharp end that penetrates the fish’s mouth or skin. The gape or gap describes the distance between the shank and the point. When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

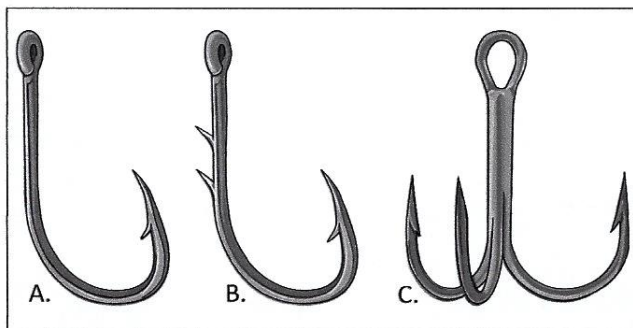
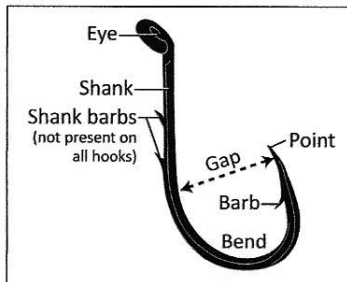


Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

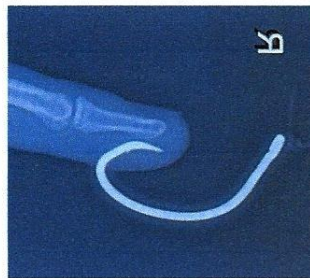


**Figure 2. Anatomy of the fishhook.** (Illustration copyright Devon Medical Art, LLC. Used with permission.)

#### PATIENT EVALUATION

After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration. Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.<sup>3</sup> Any eye injury penetrating wounds should be stabilized and transported to the nearest ED. Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

Photo courtesy of A G Stanley, MD.



#### PRINCIPLES OF REMOVAL

The six most common techniques for the removal of fishhooks are:

- |                 |                    |
|-----------------|--------------------|
| 1. Retrograde   | 4. Barb crush      |
| 2. String-yank  | 5. Cut-it-Out      |
| 3. Needle cover | 6. Advance-and-cut |

*Removed*  
*Is specifically*  
*wrote a note in the*  
*6/5/21 email to leave*  
*in my XRay!*  
*it was also removed*



The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimal, this will require:

- |                              |  |
|------------------------------|--|
| 1. Wire cutter               | 4. Wound cleanser                              |
| 2. Hemostat or needle driver | 5. Protective eyewear (goggles or face shield) |
| 3. Gloves                    | 6. Local anesthetic                            |

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia typically lidocaine 1% (Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

#### Trauma Gallery

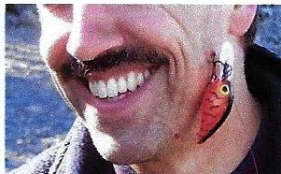


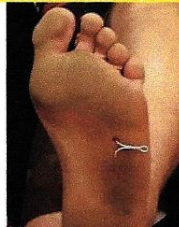
Photo courtesy of Steve Weeks.



Photo courtesy of Chris Barry.



Photo courtesy of Fishing World Magazine.

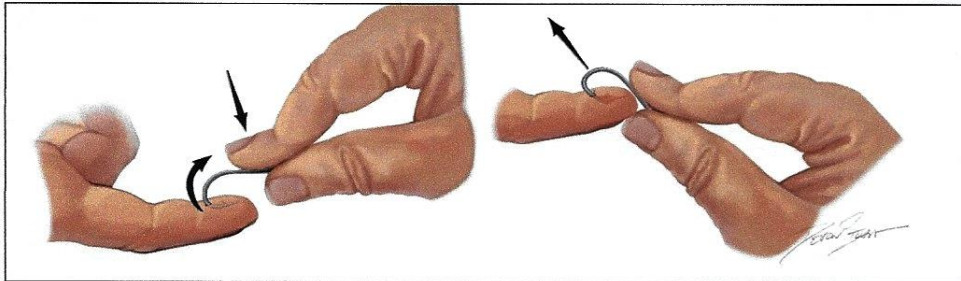


Photo(s) courtesy of Karen Rudkin-Moody and Ryan Moody.

Section 1  
Removed  
after 6/5/21

### Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (**Figure 3**). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.



**Figure 3.** Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

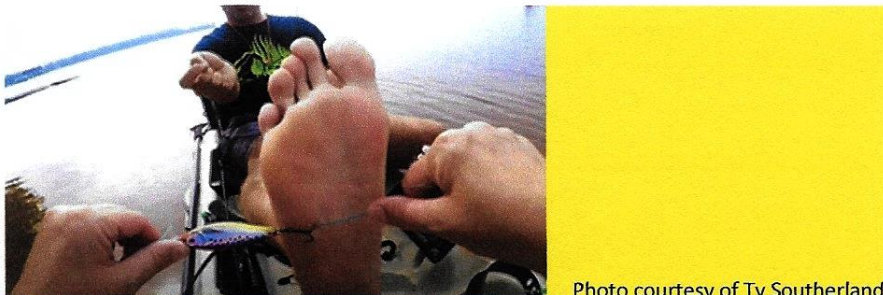


Photo courtesy of Ty Southerland.

*Removed by JUCM*

### String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of



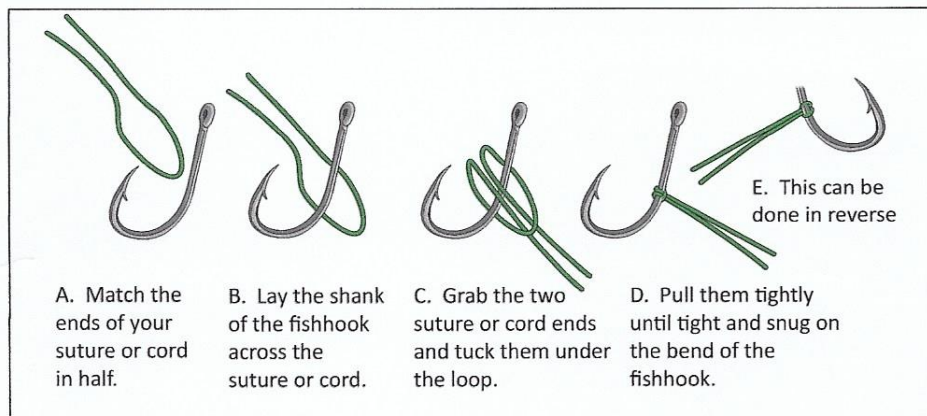
damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).

The tradition of counting *1,2,3, go* (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.

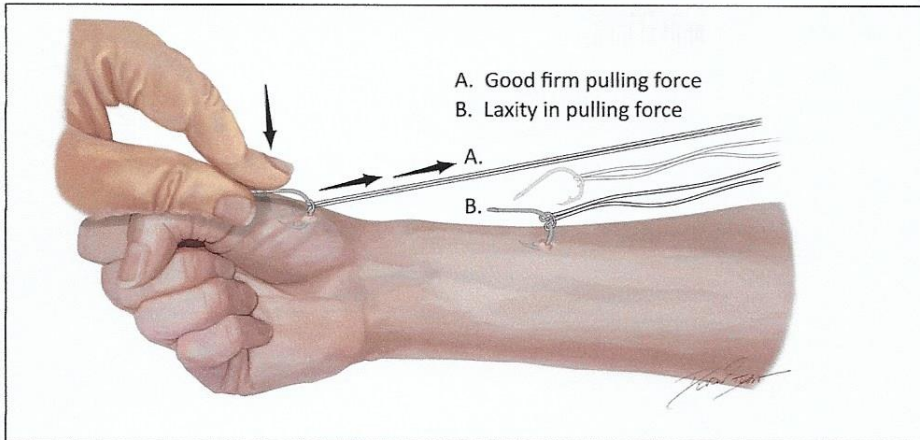
Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (**Figure 4**). Wrap the free ends around the index finger of the free hand.

A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (**Figure 5A**). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newton's third Law of Motion<sup>4</sup>; for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and be embedded into a new location (**Figure 5B**).

**Figure 4.** Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



**Figure 5.** String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



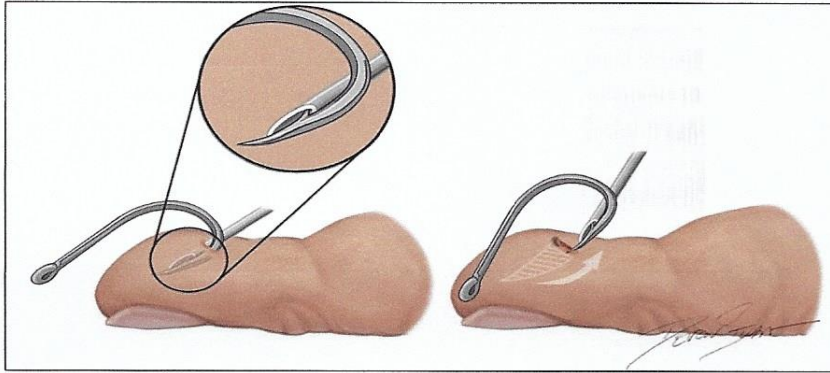
#### Needle Cover Technique

The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).

After standard wound prep and local anesthesia, a 16-18-gauge needle is advanced along the wound entrance of the fishhook (**Figure 6**). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered, back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.

**Figure 6.** Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps, the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)





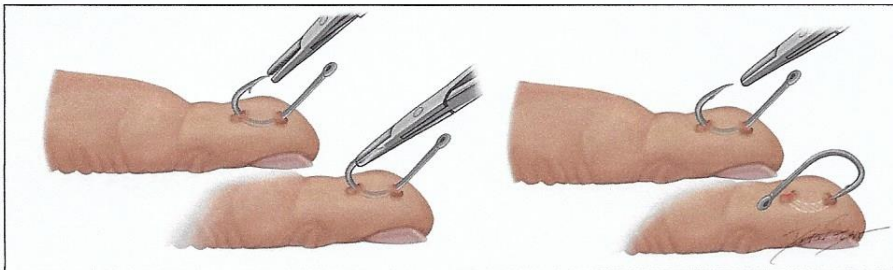
A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

#### **Barb Crush Technique**

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate.

Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (**Figure 7**).

**Figure 7.** Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

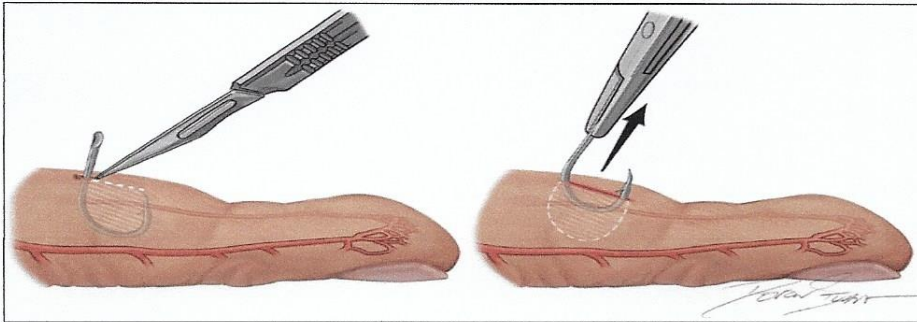


### Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.<sup>5</sup> However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See **Figure 8**) This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

**Figure 8.** Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



### Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.<sup>6</sup> It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.<sup>7</sup> Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective



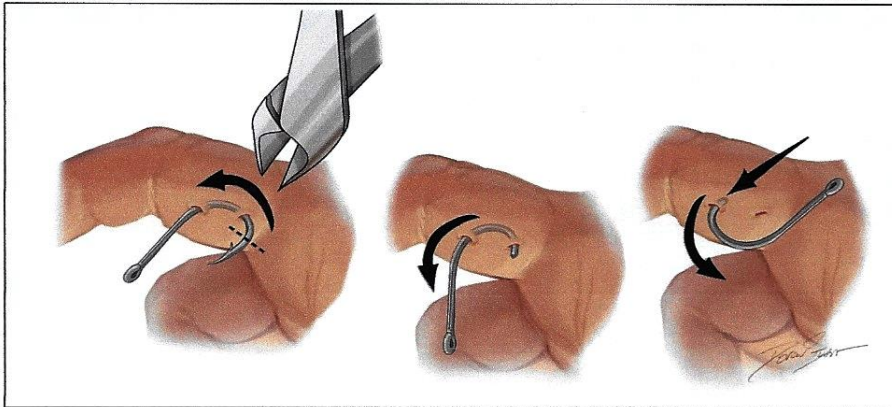
eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. **Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.**

*\*On first glance...*

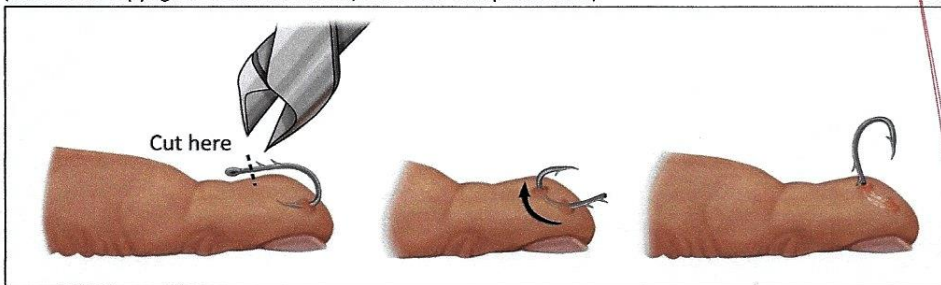
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7/1/2021*

**Figure 9.** Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



*Alex's  
JEM used me a question  
then rewrote  
i added their  
Comments*

**Figure 10.** Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



**Commented [HF1]:** Peer review question: "Would removal of the shank barbs obviate the need to drag them through the wound?"

**Commented [AS2R1]:** Harris, It is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). By cutting the tail end off, then pull thru, you are just dragging the shank barbs intact thru the tissue plane that has already been cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient and saves time of procedure. As seen on the X ray some hooks have small barbs and some larger.

**Commented [AS3R1]:**

**Commented [AS4R1]:**



### POSTREMOVAL WOUND CARE

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.

Infections after fishhook removal are uncommon.<sup>4</sup> Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

### CONCLUSION

Fishhook injuries can occur at any time—during angling, commercial fishing, or simply cleaning out the garage. There is a need to establish a basic minimal procedural understanding by all healthcare providers involved in ambulatory care, urgent care, and emergency rooms for quick assessment and swift removal of fishhooks. This is an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (ie, retrograde, needle cover) prior to the more robust methods mentioned in this article. Further, there is a need to establish a standard fishhook removal system that is as universal as the suture tray, containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies. Ensuring there is an established protocol, provider training, and a ready-to-use fishhook removal system on hand (ideally in close proximity to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction.

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### An Urgent Care Approach To Fishhook Removal

Urgent message: While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

Anthony G. Stanley, MD and Jorge Murillo, MD Citation: Stanley AG, Murillo J. An urgent care approach to fishhook removal. J Urgent Care Med. 2021;15(9):13-18. INTRODUCTION Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and ...

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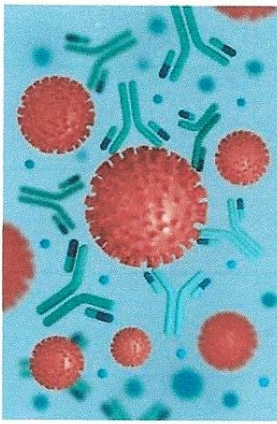
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# AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

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misinformation to the public

**Urgent message:** While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

**Anthony G. Stanley, MD and Jorge Murillo, MD** Murillo

Citation: Stanley AG, Murillo J. An urgent care approach to fishhook removal. *J Urgent Care Med.* 2021;15(9):13-18. Murillo

## INTRODUCTION

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known (or "angling"). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.<sup>1</sup> What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as collateral damage.

U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center. (The emergency department is the site for 28% of all acute care visits in the United States.<sup>2</sup>) From this author's experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there's a fishhook injury in the waiting room.

Fishhook removal is a procedure comparable in difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile device similar to the standard suture tray. Here, we review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal and injury management. To do so, it is essential to understand the anatomy of the fishhook, the

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injured area, and common techniques used to remove fishhooks in a timely and safe manner with minimal trauma.

## ANATOMY OF THE FISHHOOK—AND WHY IT MATTERS

The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be accessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the “eye” connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The “point” is the sharp end that penetrates the fish’s mouth or skin. The gape or gap describes the distance between the shank and the point. When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook.

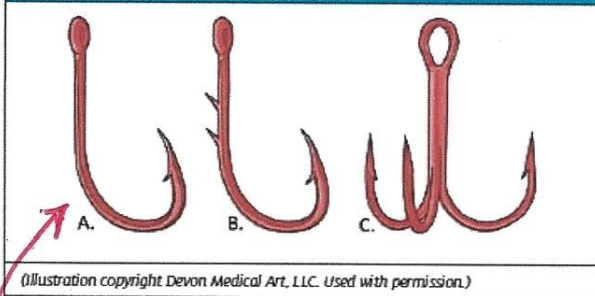
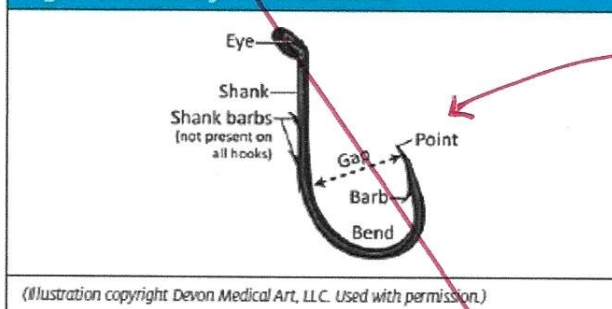


Figure 2. Anatomy of the fishhook.



## PATIENT EVALUATION

After obtaining a history of the injury, vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury

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involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration.

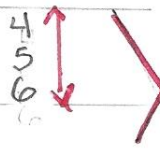
Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.<sup>3</sup> Any eye injury penetrating wounds should be stabilized and transported to the nearest ED. Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

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## PRINCIPLES OF REMOVAL

The six most common techniques for the removal of fishhooks are:

1. Retrograde
2. String-yank
3. Needle cover
4. Barb crush
5. Cut-it-out
6. Advance-and-cut

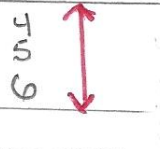


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The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimal, this will require:

1. Wire cutter
2. Hemostat or needle driver
3. Gloves
4. Wound cleanser
5. Protective eyewear (goggles or face shield)
6. Local anesthetic



This Lay out Saves Space

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times multiple techniques must be attempted before the fishhook is successfully removed.

In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia typically lidocaine 1%

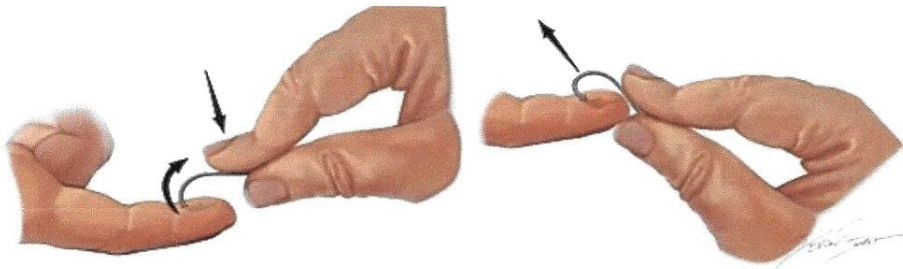
#22 JUCM Interjection of Personal Comments

(Xylocaine) without epinephrine. A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook should have the free barbs taped or cut to avoid additional embedded puncture wounds during the removal procedure. All items attached to the hook (eg, fish line, bait, and the body of the lure itself) should be removed. The provider and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

## Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and

dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (**Figure 3**). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.



**Figure 3.** Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. (Illustration copyright Devon Medical Art, LLC.

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## String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).

The tradition of counting *1,2,3, go* (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.

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Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (**Figure 4**). Wrap the free ends around the index finger of the free hand. A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (**Figure 5A**). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newton's third Law of Motion<sup>4</sup>; for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and be embedded into a new location (**Figure 5B**).



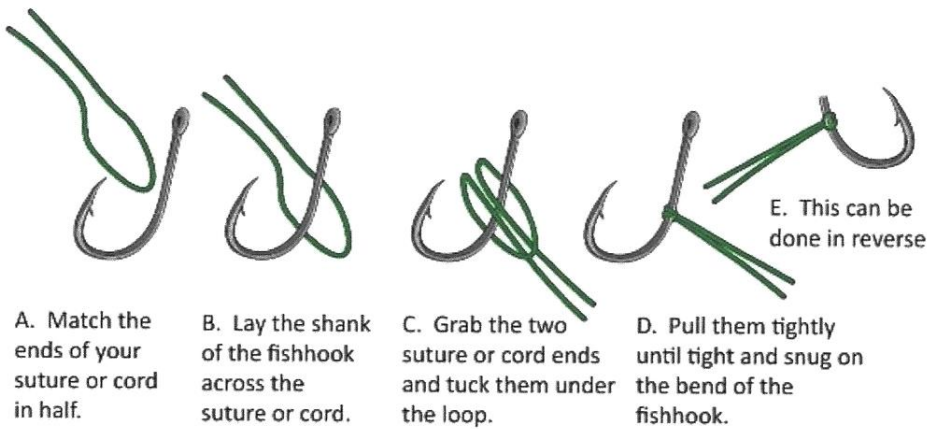


Figure 4. Applying a lark's head knot to a fishhook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

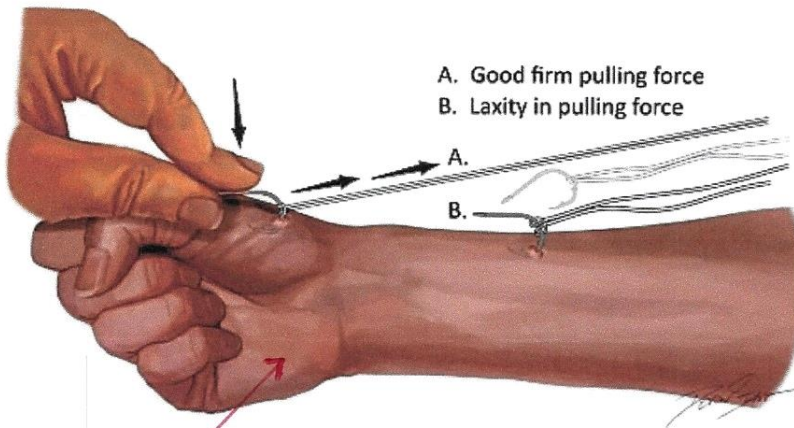


Figure 5. String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

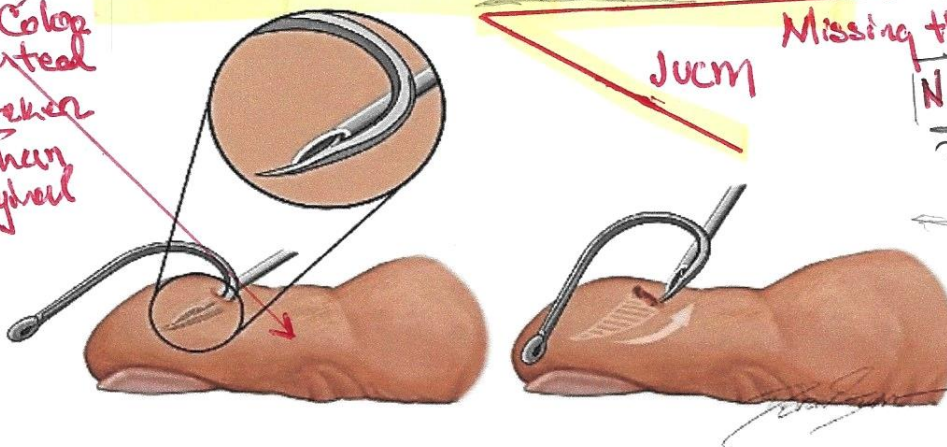


Figure 6. Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps the barb. The fishhook and needle are then pulled back and removed as a single unit. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

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Information Goes above Fig 6.

#29

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A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out thru the track of the incision line.

## Barb Crush Technique

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate. Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 7).



**Figure 7.** Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

## Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.<sup>5</sup> However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present. To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See Figure 8) This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

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**Figure 8.** Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. (Illustration copyright Devon Medical Art, LLC. Used with permission.)

## Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.<sup>6</sup> It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.<sup>7</sup> Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. **Bear in mind that** all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been cut from the initial puncture

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#33

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wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.

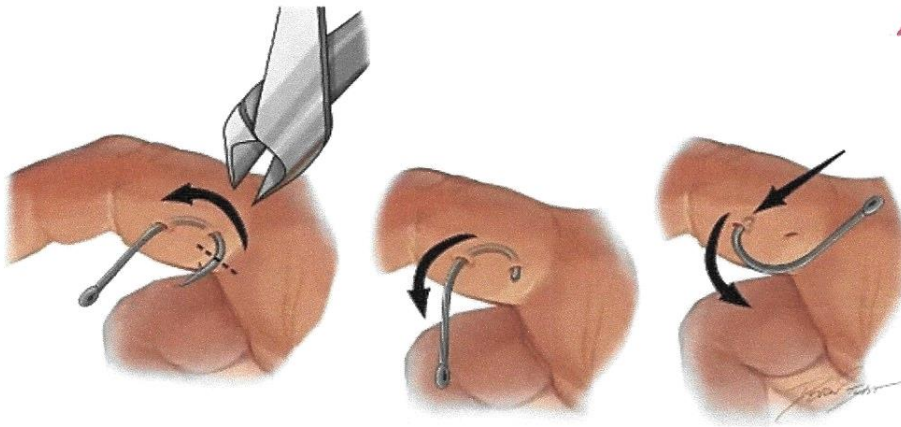
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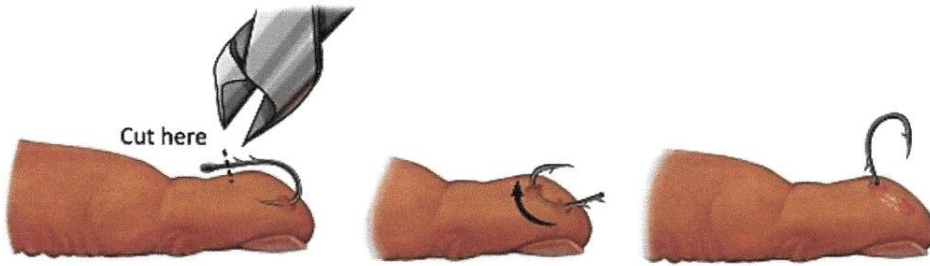
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**Figure 9.** Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point. (Illustration copyright Devon Medical Art, LLC. Used with permission.)



**Figure 10.** Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin.

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## POSTREMOVAL WOUND CARE

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.

Infections after fishhook removal are uncommon.<sup>1</sup> Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

## CONCLUSION

Fishhook injuries can occur at any time—during angling, commercial fishing, or simply cleaning out the garage. There is a need to establish a basic minimal procedural understanding by all healthcare providers involved in ambulatory care, urgent care, and emergency rooms for quick assessment and swift removal of fishhooks. This is an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (ie, retrograde, needle cover) prior to the more robust methods mentioned in this article. Further, there is a need to establish a standard fishhook removal system that is as universal as the suture tray, containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies. Ensuring there is an established protocol, provider training, and a ready-to-use fishhook removal system on hand (ideally in close proximity



to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction.

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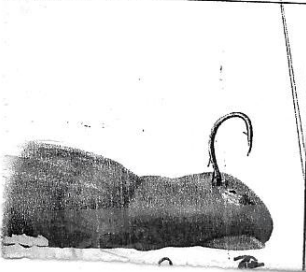
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6/5/21 Question From MR. HARRIS Fleming

Advance the fishhook  
off and pull the remaining  
oint through the skin.



**Commented [HF1]:** Peer review question: "Would removal of the shank barbs obviate the need to drag them through the wound?"

**Commented [AS2R1]:** Harris, It is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). By cutting the tail end off, then pull thru, you are just dragging the shank barbs intact thru the tissue plane that has already been cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient and saves time of procedure. As seen on the X ray some hooks have small barbs and some larger.

**Commented [AS3R1]:**

**Commented [AS4R1]:**

**Exhibit C – “Violations in the Printed Version”**



# JUCM<sup>®</sup>

THE JOURNAL OF URGENT CARE MEDICINE<sup>®</sup>

JUNE 2021

VOLUME 15, NUMBER 9

Journalist  
Confusion!

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CLINICAL **cme**

## Gone Fishin, Then Going to Urgent Care

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- 21 Case Report**  
Don't Let Anchoring Bias Sink Your Patient's Chance for Survival
- 25 Original Research**  
Keep Them Waiting, and You'll Keep Them Away—Why You Must Break Through Bottlenecks
- 34 Clinical**  
Follow the Evidence to Keep Concussion Patients Safe
- 38 Pediatric Urgent Care**  
'Usually Benign' Shouldn't Keep You from Digging for the Right Diagnosis



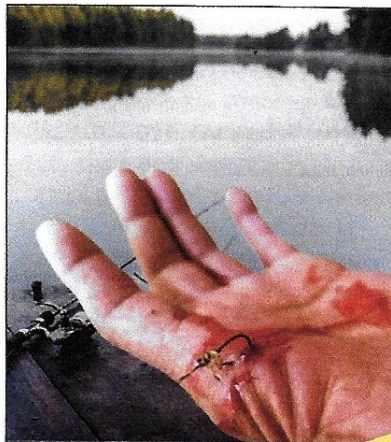
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June 2021 | VOLUME 15, NUMBER 9



## CLINICAL

### 13 An Urgent Care Approach to Fishhook Removal

*Gone fishin'* usually signals a blissful experience in nature—until fishhook meets human flesh, at least. When patients present with a sharp, barbed metal object embedded in one body part or another, you'll need a sound understanding of the type of hook you're dealing with, the corresponding proper technique for removal, and what the next steps should be.

Anthony G. Stanley, MD and Jorge Murrilo, MD

## CASE REPORT

### 21 A 'Red Herring' Chief Complaint

The patient's account of what brought them to the urgent care center is the foundation of the history. However, falling victim to anchoring bias could have devastating consequences.

Ryan Hagan, PA-C and  
Christina Gardner, DHSc, MBA, PA-C

## ORIGINAL RESEARCH

### 25 More Timely Care: Effect of Online Queuing vs Change in Hours of Operation on Hourly Arrival Volumes. A Practice Management Reflection

Bottlenecks can be the bane of the urgent care operator's existence. What's the best solution (or better yet, preventive measure), though?

Aimy Patel, MD; Jennifer Johnson, MD;  
Brian R. Lee, PhD, MPH;  
Amanda Montalbano, MD, MPH

## CLINICAL

### 34 Managing Concussion in Acute Care



Knowing the best approach to managing patients who may have sustained a concussion starts with recognizing the signs and grasping the relative merits of the rest vs return-to-activity approaches.

Jordan Wackett, MD, MPH, Joshua Kornegay, MD, and Craig Rudy, MD

## PEDIATRIC URGENT CARE

### 38 Febrile Seizure: An Urgent Care Overview



Identifying the type of seizure and causes of fever are the essential first steps.

Tiffany Addington, MD

## NEXT MONTH IN JUCM

The sight of blood is always unsettling to the patient and their loved ones. While it's likely to be less disconcerting to healthcare professionals, bleeding without an obvious cause is concerning even when the presentation is something as common as epistaxis. Vital signs, location of the bleeding, and patient history are essential to understanding the etiology. Familiarity and comfort with certain procedures are necessary for a positive outcome. Reading the cover article in the July/August issue of JUCM will help you feel confident that you'll be prepared.

## DEPARTMENTS

- 1 Letter from the Editor-in-Chief
- 9 From the UCA CEO
- 10 Continuing Medical Education
- 43 Insights in Images
- 50 Abstracts in Urgent Care
- 53 Revenue Cycle Management Q&A
- 57 Developing Data

## CLASSIFIEDS

- 55 Career Opportunities

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## Clinical

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# An Urgent Care Approach to Fishhook Removal

False  
Narratives  
↙

**Urgent message:** While fishhook injuries are common in urgent care centers located in or near recreation areas, especially during vacation season, their untimely presentation can cause pandemonium in the office. Management requires a thorough understanding of the mechanism of injury, the type of hook involved, and proper technique for removal.

ANTHONY G. STANLEY, MD and JORGE MURRILO, MD

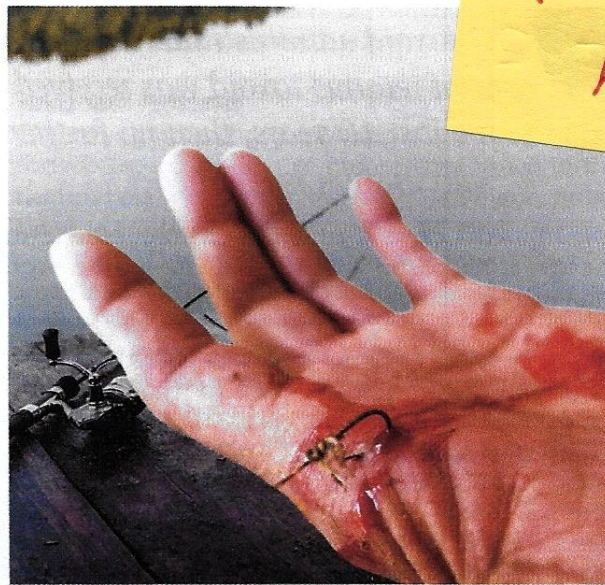
**Citation:** Stanley AG, Murrilo J. An urgent care approach to fishhook removal. *J Urgent Care Med.* 2021; 15(9):13-18.

## Introduction

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line (or "angling"). There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.<sup>1</sup> What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as *collateral damage*.

U.S. data on actual incidence of fishhook injuries are scarce, as many such injuries are treated in the field without attention from a healthcare provider. However, the presumption is that patients who seek medical care do so in the emergency room, an urgent care center, or in an ambulatory care center. (The emergency department is the site for 28% of all acute care visits in the United States.<sup>2</sup>) From this author's experience, pandemonium commences as soon as front desk personnel in the urgent care center announce there's a fishhook injury in the waiting room.

Fishhook removal is a procedure comparable in



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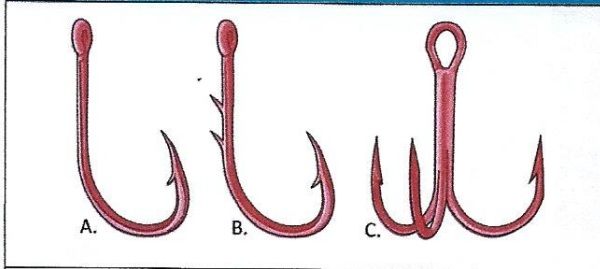
difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile device similar to the standard suture tray. Here, we review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal and injury management. To do so, it is essential to understand the anatomy of the fishhook,

**Author affiliations:** Anthony G. Stanley, MD, Criticare Clinics & Urgent Care, Miami, FL; Baptist Healthcare of South Florida; Stanley Medical Designs. Dr. Stanley holds patents for three medical devices, but has no relevant outside financial relationships with any commercial interests. Jorge Murrilo, MD, FIDSA, FACP, Herbert Wertheim College of Medicine, Florida International University; Baptist Health System of South Florida. Dr. Murrilo has no relevant financial relationships with any commercial interests.



## AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Figure 1. Classic types of fishhooks: A, single barbed fishhook; B, multiple barbed fishhook; C, treble fishhook.



(Illustration copyright Devon Medical Art, LLC. Used with permission.)

*"Tetanus-diphtheria or tetanus-diphtheria-pertussis vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required."*

the injured area, and common techniques used to remove fishhooks in a timely and safe manner with minimal trauma.

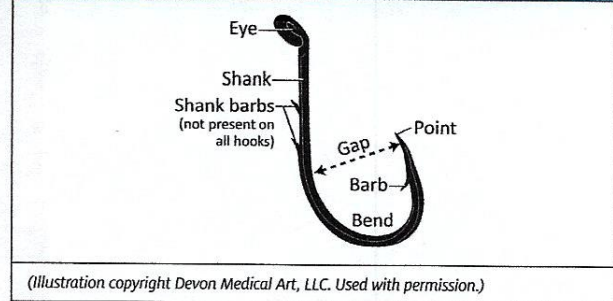
#### Anatomy of the Fishhook—and Why It Matters

The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be ascertained.

There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble (Figure 1). There are common features among them, however (Figure 2). In each, the "eye" connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The "point" is the sharp end that penetrates the fish's mouth or skin. The gape or gap describes the distance between the shank and the point.

When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-

Figure 2. Anatomy of the fishhook.



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barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.

#### Patient Evaluation

After obtaining a history of the injury and vital signs, a quick survey of the wound and surrounding structures should be made. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration.

Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head, or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape of the fishhook that brings the point parallel to the skin and keep it from deep penetration.<sup>3</sup> Any eye injury penetrating wounds should be stabilized and transported to the nearest ED.

Bear in mind that the cutting capacity of wire cutters is limited. In cases involving larger fishhooks, the patient may have to be referred to the ED where larger surgical cutting devices are available (ie, bolt cutter or an extensive surgical procedure may be required).

#### Principles of Removal

The six most common techniques for the removal of fishhooks are:

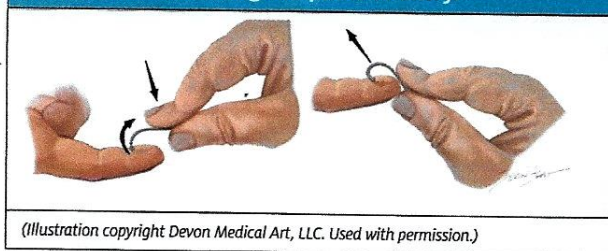
1. Retrograde
2. String-yank
3. Needle cover
4. Barb crush
5. Cut-it-out
6. Advance-and-cut

The method selected is based on the judgment of



## AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

**Figure 3. Retrograde technique.** Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry.



the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before you get started make sure that you have of a fishhook removal system. At minimum, this will require:

1. Wire cutter
2. Hemostat or needle driver
3. Gloves
4. Wound cleanser
5. Protective eyewear (goggles or face shield)
6. Local anesthetic

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank methods). Often times, multiple techniques must be attempted before the fishhook is successfully removed.

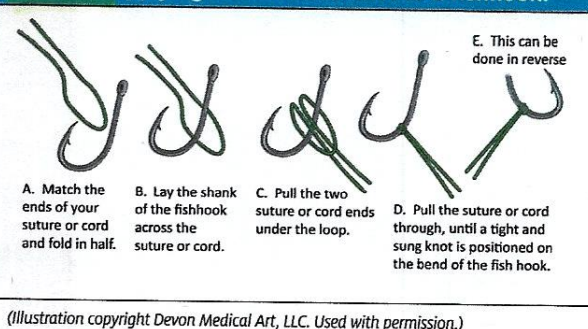
In the clinical setting, local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, hexachlorophene solution before attempting removal of the fishhook. Patients who contact the urgent care center before arrival can be advised to wash the wound with soap and water. Local anesthesia is typically administered with 1% (Xylocaine) without epinephrine or regional block at the injury site.

Hooks with barbs should be removed like the treble fishhook should be removed or cut to avoid additional damage during the removal process. The hook (eg, fish line, bait, etc.) should be removed. The hook itself should be removed. The hook should take care not to be struck during removal. Anyone assisting with the removal should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the string-yank method and advance-and-cut method.

#### Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It

**Figure 4. Applying a lark's head knot to a fishhook.**



works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb from the resting tissue site. The hook can then be backed out of the skin along the path of entry (Figure 3). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.

#### String-Yank Technique

The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).

The tradition of counting 1,2,3, go (to give a reference point in time to start) prior to performing a yank-pull attempt is not advised as it may prompt patients to assume a flexed posture, which can cause more damage during the course of pulling. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used.

Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position; use a simple knot such as a lark's head knot (Figure 4). Wrap the free ends around the index finger of the free hand.

A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft.

The involved skin area should be well stabilized

Diagram  
Hook  
Positioned

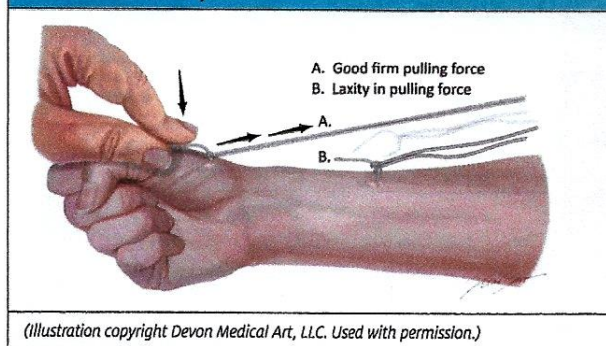
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## AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

**Figure 5. String-yank method.** A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook.



against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (Figure 5A).

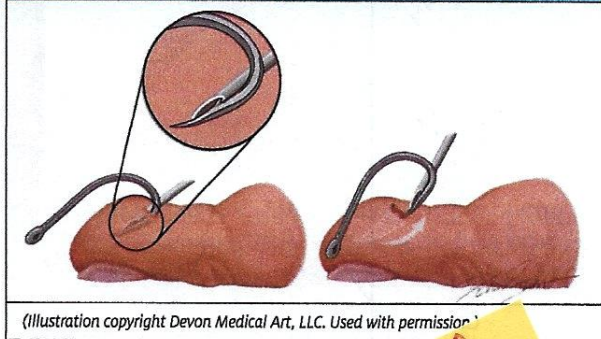
Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newton's third Law of Motion<sup>4</sup>; for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can come out of its original position and be forcefully pulled back and become embedded into a new location (Figure 5B).

#### Needle Cover Technique

The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).

After standard wound prep and local anesthesia, a 16- to 18-gauge needle is advanced along the wound entrance of the fishhook (Figure 6). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel

**Figure 6. Needle cover method.** Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps the barb. The fishhook and needle are then pulled back and removed as a single unit.



pointed in the correct direction so that the leading edge of the needle is against the fishhook barb. Advance the needle until the needle opening covers or caps the barb, then pull and wiggle the needle back and forth to move the needle along the fishhook (similar to the retrograde technique) to move the needle along the fishhook.

A modification of this technique involves using a #11 scalpel blade along the wound entrance of the fishhook. The fishhook may then be pulled back and removed through the track of the incision line.

#### Barb Crush Technique

The barb crush technique is considered a modification of the retrograde technique, but with a higher success rate.

Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (Figure 7).

#### Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.<sup>5</sup> However, this should be a procedure of last resort in the ambulatory care setting,

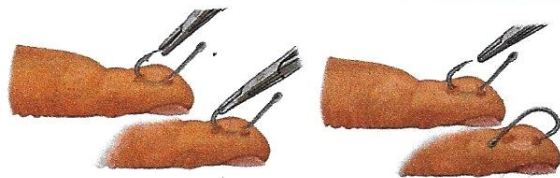
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# AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

**Figure 7. Barb crush method.** Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes.



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**Figure 8. Cut-it-out technique.** Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment.



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when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded. (See **Figure 8**.) This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

## Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.<sup>6</sup> It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off prior to attempting removal.

Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin; alternatively, a digital or regional block may be appropriate for various body site injuries.<sup>7</sup> Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (in the entire barb) upward through the skin, creating an exit wound. A modification of note is to open with a #11 scalpel blade, slightly above the point of the hook to allow easier exit. Once the shaft of the fishhook completely clears the skin, cut it with a medical wire cutter or another

tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury.

The advance-and-cut technique is likely to be the most universally accepted in the urgent care, ambulatory care, and ED settings as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. Bear in mind that all wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the ED or hospital where a bolt cutter or surgical procedure may be required.

On first glance, it may appear that removing the shank barbs could obviate the need to drag them through the wound. However, it is difficult to stabilize the hook with a hemostat and try to remove the small multiple shank barbs (creating potentially multiple small flying objects as you try to snip them off). Cutting the tail end off, then pulling through, amounts to dragging the shank barbs intact through the tissue plane that has already been cut from the initial puncture wound. This results in less risk of injury to the provider, less anxiety to the patient, and saves time of procedure.

Medical Advice Not authorized

## Wound Care

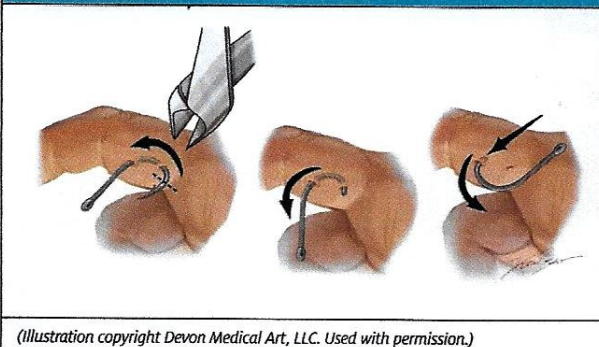
After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and blood should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include rou-



## AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

Photos go on Page # 17

Figure 9. Advance-and-cut technique with a single barb fishhook. Advance the fishhook through the skin, creating an exit wound. Cut off the barb of the fishhook and back the remaining fishhook out the entry point.



*"Risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method."*

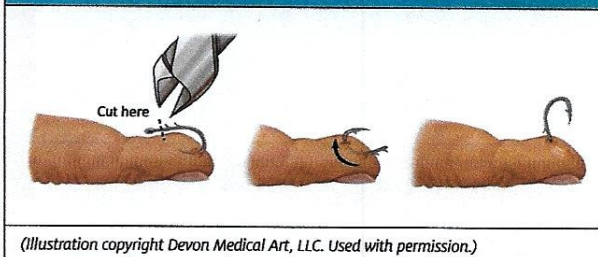
tine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed. Infections after fishhook removal are uncommon.<sup>1</sup> Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason for suspicion of infection and antibiotics are prescribed, consideration of coverage for water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

### Conclusion

Fishhook injuries can occur at any time—during angling, commercial fishing, or simply cleaning out the

Figure 10. Advance-and-cut technique with a multiple barb fishhook. Advance the fishhook through the skin creating an exit wound. Cut the eye of the fishhook off and pull the remaining fishhook forward through the exit wound created by advancing the point through the skin.



garage. There is a need to establish a basic minimal procedural approach by all healthcare providers in the emergency department, urgent care, and emergency room. Prompt and swift removal of fishhook injuries requires risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider the patient's safety and comfort. Removal techniques (ie, the advance-and-cut technique) are superior to the more robust methods (ie, the cut-and-pull technique).

Further, the use of a standard fishhook removal tray, containing a suture, a suture tray, containing a suture, along with hemostatic forceps, and other supportive care supplies, is essential.

Ensuring there is a standard protocol, provider training, and a readily available fishhook removal system on hand (ideally in close proximity to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction. ■

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Photos belong on Page # 17



**Exhibit D – “Retraction Petition”**

**Petition for Article Retraction**

To: Braveheart Group LLC d/b/a "The Journal of Urgent Care Medicine"  
185 State Route 17, Suite 4  
Mahwah, NJ 07430

Dear Journal of Urgent Care Medicine (JUCM):

We the undersigned are licensed medical providers (MD, DO, ARNP, PA-C, RN) working in the Urgent Care setting. We the undersigned are familiar with caring for fishhook injured patients, with Dr. Stanley and his work in fishhook removal education over the past several years.

Upon reading the article in your JUCM magazine on-line and printed dated June 1, 2021, entitled "An Urgent Care Approach to Fishhook Removal" we have been unfortunately surprised by the medical misinformation multiple grammatical errors that the JUCM publication presented to the medical community. We've had the opportunity of reading Dr. Stanley's original article entitled "Clinical Approach to Fishhook Removal" and the JUCM's printed version entitle "An Urgent Care Approach of Fishhook Removal" for comparative purposes and have reached the following conclusions.

The current JUMC article gives the reader, a viewpoint that fishhook injured people go to the Urgent Care centers, located in recreation areas, and that they go to the Urgent Cares, during the vacation season. These three unverified clinical assumptions are not factual medical information. There is no National data on the incidence of fishhook injury, no information on seasonal incidence, no information on geographical or regional location centers of concentrated injury. If you read the printed article's citation # 2, you will find no information to support the claims stated in the article regarding the incidence and occurrence of Fishhook injury.

The original article as written by Dr. Stanley was geared to alert the reader of the mindfulness of needing to track valuable incidence data and bring about a renewed approach to fishhook injury and treatment strategies. In reading the printed JUCM version in comparison to the original version it is evident that Dr. Stanley's information was cut and pasted out of the article, producing multiple typographical errors, and leaving poorly explained, disjointed medical concepts (e.g., "Fish hook Removal System") and, leaving the reader with only technical information of fishhook removal.

The original article furthermore has several pictures of actual patients who have provided their consent to use the images in question to bring home several points of injury awareness and diversity in skill needed to consider removal of this type of foreign body. All photos in the original article and related information were unexplainably deleted in the final version. It is, however, noticeable that JUCM has placed their own photos in the published article.


We have analyzed both versions of the article in question and believe that the readers were denied the full scope of Dr. Stanley's insight into this field of medicine, and ultimately denied valuable clinical information intended for the provider who will be faced with the difficult challenge of removing fishhooks from patients. Further, the article has

excessive brightly colorized diagrams that are of unacceptable poor visibility, all instructional diagrams listed in the article are located at the top of the pages and do not flow with the written text easily as originally intended. This arrangement requires the readers to constantly look up and look down and could potentially lead to them becoming confused. Providers, who may need to reference this article quickly in current format, (which is full of grammatical errors, disjointed through concepts and difficult to follow text) could become confused.

In conclusion, this current article "An Urgent Care Approach to Fishhook Removal" is drastically different from its original easy-to-follow format/ layout. As a result of these numerous errors and clinical omissions listed above, the use of the article as currently published could adversely affect the care of patients and may result in injuries if not retracted and amended.

For the aforementioned reasons:

- We the undersigned medical practitioners, support a complete retraction of the article "An Urgent Care Approach to Fishhook Removal" (attached to herein in Exhibit A) in all media forms to mitigate or reduce risk to patients, ensure patient safety and satisfactory outcome.
- We the undersigned medical practitioners, support that an updated version of the article (attached to herein as Exhibit B) be published in the same edition or issue of the newspaper or periodical in which said article appeared and in as conspicuous place and type as said original article (both online and printed versions) in the Journal of Urgent Care Medicine.

By:  \_\_\_\_\_

Virginia Sardinias, ARPN

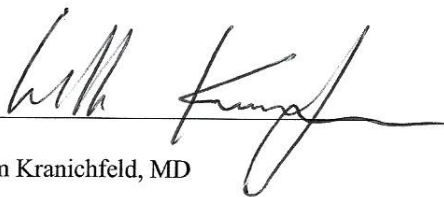
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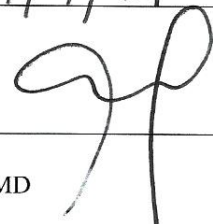
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By:   
William Kranichfeld, MD


Medical Director Criticare Clinics Urgent Care

Date: 9/17/21

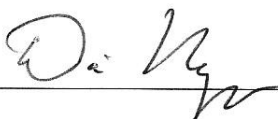
By:   
Ernesto Sanz, MD

Medical Director Criticare Clinics Urgent Care


Date: 9/17/21

By:   
Betty Ruiz, ARNP


Date: 09/17/21

By:   
Dia Nguyen, MD

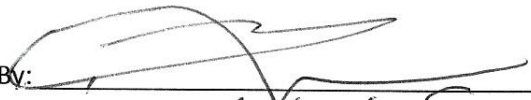
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By:   
Yenny Ceballos, ARNP

Date: 9/8/21

By:   
Anisleydi Pardon, ARNP

Date: 9/18/2021

By:   
Name/Title: Michael Sason DO  
Date: 09-08-21

By:   
Name/Title: Bonnie J. O'Sullivan MD  
Date: 9/13/21

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Date: \_\_\_\_\_

**Exhibit E – “Updated Article”**



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## Clinical Approach to Fishhook Removal

Anthony G. Stanley, MD and Jorge Murillo, MD

### Key Concepts

Fish hook removal system

Risk Recognition

Patient satisfaction & experience

Shorter registration to discharge times

**Urgent Message** Fishhook injuries occur year-round under various circumstances, as simple as cleaning out the trunk of your car or garage. Upon arrival at the health care facility, *“there is often, office pandemonium once the receptionist gives notification of a fish hook injury in the waiting room”*

### Navigate this Article

- Abstract / Introduction
- Relevance in today’s health care system
- Anatomy of the Fish Hook
- Patient Evaluation
- Principles of Removal
- Fishhook Removal System
- Techniques
- 1 Retrograde Technique
- 2 Needle Cover Technique
- 3 String-Yank Technique
- 4 Barb Crush Technique
- 5 Cut it out Technique
- 6 Advance and Cut Technique
- Post-Removal Wound Care
- Conclusion
- References

Lead internet photo(s)



Photo courtesy of Thundermist Lure



Photo courtesy of Richard Gene

## INTRODUCTION

Fishhook injuries are a common, underestimated occurrence presenting to emergency rooms, ambulatory care, and urgent care facilities, especially among those who participate in the sport of fishing with a rod and line known as “angling”. There are also multiple injuries in the commercial fishing industry. The vast majority of fishhook injuries occur to the head and hands.<sup>1</sup> What has been seldomly recognized is the occurrence of injury to bystanders, as well as to accompanying pets and wildlife. These types of injury are referred to as “*collateral damage*” as noted in our *Trauma Gallery*.

National data reveal, the emergency department is the site for 28% of all acute care visits in the United States.<sup>2</sup> How common is a fish hook injury? This is a commonly asked question, and very little national data exist on this specific type of injuring. The incident of this type of injury is an area where more clinical research is needed. Fishhook injuries that are not treated in the field will present to the ER, ambulatory care or urgent care centers. When these injuries present to the health care facilities, “there is often, office pandemonium once the receptionist gives notification of a fishhook injury in the waiting room”. Besides the high anxiety felt by the patient, the staff also goes through an equivalent experience. There is disruption in continuity in the care of patients already in the treatment area, due to staff frantically making phone calls searching for a fishhook removal device. Many of the commonly used wire cutters, are only sanctioned for home repairs and electrical work use. Currently there is no medical fishhook removal system established. In addition to locating a wire cutting tool for removal, the provider must be familiar with the anatomy of the fishhook, the anatomy of injured area and well versed in common techniques used to remove fishhooks in a timely and safe manor with minimal trauma. The confidence of the provider, availability of the removal system, gives the patient assurance they are in great hands and reduces anxiety. Often because of unavailability of established medical fish hook removal system(s), clinician’s lack of removal experience, many of these cases are simply screened by the nurse and provider then sent to the ER for removal. Fishhook removal is a procedure comparable in difficulty to laceration repair of the skin with proper equipment. The fishhook removal system can be either disposable or a reusable sterile medical device similar to, the standard suture tray.

This article will review the clinical approach to evaluation and removal of fishhooks, focusing on the six most common techniques of fishhook removal, injury management and the mindfulness of establishing a formal fishhook removal system. The choice of the method for fishhook removal depends on the type of fishhook embedded, the location of the injury, and the depth of tissue penetration. Occasionally, more than one removal technique may be required for removal of the fishhook. Wound care following successful removal involves extraction of foreign bodies from the wound and the application of a simple dressing. Prophylactic antibiotics are generally not indicated, and should be left up to the discretion of the provider. Tetanus status should be assessed and Td or Tdap administered if needed with age appropriateness as per established guidelines.

### Trauma Gallery



Photo courtesy of Steve Weeks



Photo courtesy of Chris Barry



Photo courtesy of *Fishing World Magazine*



Photo(s) courtesy of Karen Rudkin-Moody and Ryan Moody



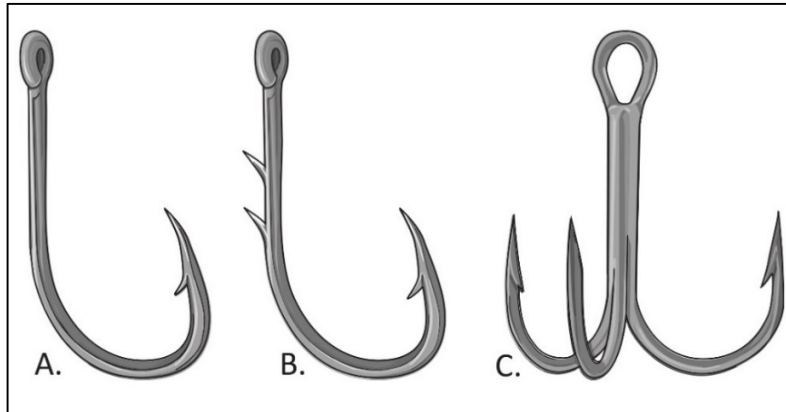
Photo courtesy of Thundermist Lure Company

### ANATOMY OF THE FISHHOOK

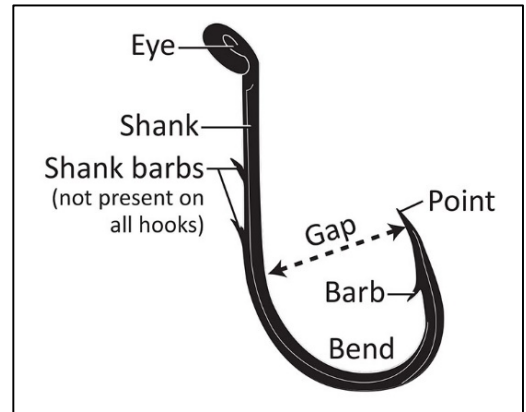
There are three classic types of fishhooks: single-barbed, multiple-barbed, and treble as seen in (Figure 1). Common features of fishhooks seen in (Figure 2). The “eye” connects the hook to the fishing line. The shank is the portion of the hook that connects the point and the eye. The “point” is the sharp end that penetrates the fish’s mouth or skin. The gape or gap describes the



distance between the shank and the point. When examining the patient, it is important to note whether the fishhook is single-barbed or multiple-barbed, as well as the number and location of the barbs; these details will help determine the optimal removal technique. Often, patients will know the type of hook they were using and, in many cases, they bring in a sample or photo of the embedded hook for viewing.



**Figure 1. Classic types of fishhooks: A. single barbed fishhook; B. multiple barbed fishhook; C. Treble fish hook.** ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")



**Figure 2. Anatomy of the fishhook.** ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")

## PATIENT EVALUATION

After obtaining a history of the injury, vital signs, examine the wound and surrounding structures. Inspect distal and proximal to the injury site. Assess for deep injury involving penetration to tendons, nerves, and bone. Radiographs are seldom needed, but may aid in determining the type of fishhook and the depth of penetration. Most fishhook injuries are penetrating soft-tissue injuries of the hand, face, head or upper extremity but can involve other body parts. Injuries usually do not involve deeper tissue structures because of the linear forces applied along the fishing line to the curved shape fishhook that brings the point parallel to the skin and keep it from deep penetration.<sup>3</sup> Any eye injury penetrating wounds should be stabilized and transported to the nearest emergency room. Keep in mind, all wire cutters have a limitation in cutting capacity. In cases involving larger fishhooks, the patient may have to be referred to the ER where larger surgical cutting devices are available (e.g., bolt cutter or an extensive surgical procedure may be required).

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## PRINCIPLES OF REMOVAL

The six most common techniques for the removal of fishhooks are:

- |                 |                    |
|-----------------|--------------------|
| 1. Retrograde   | 4. Barb crush      |
| 2. Needle cover | 5. Cut-it-Out      |
| 3. String-yank  | 6. Advance-and-cut |

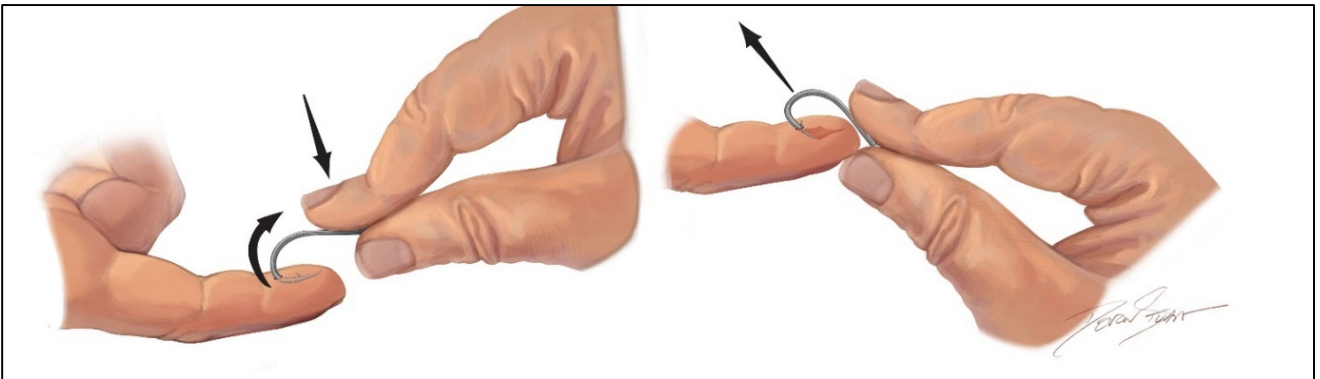
The method selected is based on the judgment of the provider, the anatomic location of the injury, and the type and anatomy of fishhook. Before getting started make sure you have a fish hook removal system, this will require:

- |                              |  |
|------------------------------|--|
| 1. Wire cutter               | 4. Wound cleanser                              |
| 2. Hemostat or needle driver | 5. Protective eyewear (goggles or face shield) |
| 3. Gloves                    | 6. Local anesthetic                            |

The approach of removal is multifactorial. In the field with limited resources, the more robust methods are generally attempted commonly (string-yank method). Often times multiple techniques must be attempted before the fishhook is successfully removed. In the clinical setting local wound care should be performed first. This typically involves cleaning the site with combination of povidone-iodine, Hexachlorophene solution or if not available use soap and water before attempting removal of the fishhook. Local anesthesia typically Lidocaine 1% (Xylocaine) without epinephrine, A nerve block or regional block may also be required depending on the injury site. Hooks with more than one point like the treble fishhook, should have the free barbs taped or cut to avoid receiving additional embedded puncture wounds during the removal procedure. All items attached to the hook (i.e., fish line, bait and the body of the lure itself) should be removed. The physician and bystanders should take care not to be struck by the hook during removal. Anyone assisting with the procedure should have clean hands and gloves. Protective eyewear should be worn with all procedures, especially when performing the String-Yank method and Advance and Cut method.

### Retrograde Technique

Retrograde technique is considered the simplest of the removal techniques but has the lowest success rate. It works well for barbless and superficially embedded hooks. Downward pressure is applied to the shank of the hook. This maneuver pushes the hook deeper into the tissue bed and dislodges the barb, from the resting tissue site. The hook can then be backed out of the skin along the path of entry (**Figure 3**). If there is any resistance or snagging sensation of the barb during the procedure, consider an alternate method.



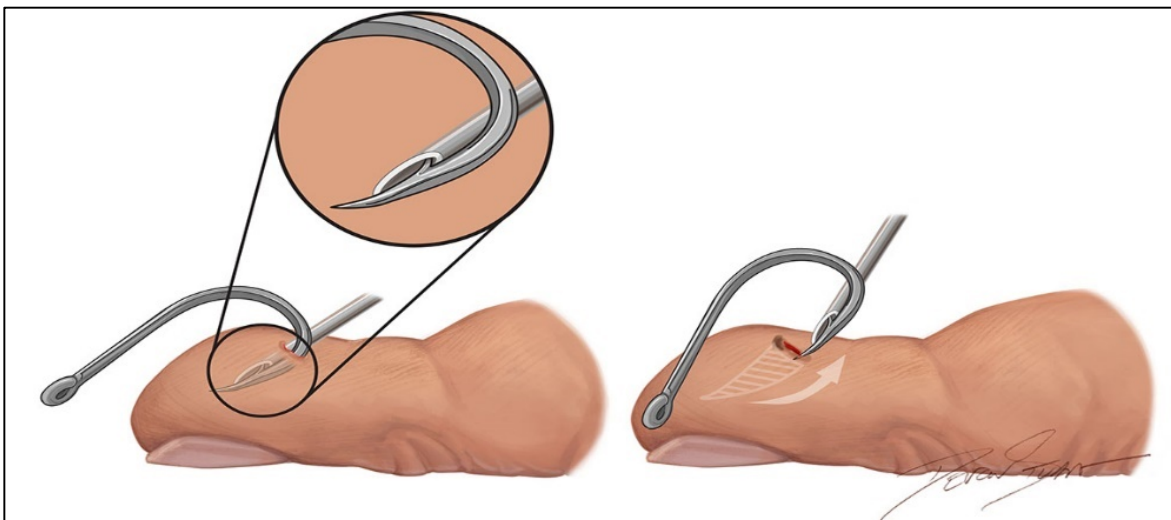
**Figure 3.** Retrograde technique. Apply downward pressure to the shank of the fishhook while it's being pushed back out along the point of entry. ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")

### Needle Cover Technique

The needle cover technique requires great dexterity on the part of the provider (and a little luck). It works well for the removal of large hooks with a single barb, and when the point of the fishhook is superficially embedded in the skin (surface).

After standard wound prep and local anesthesia, a 16-18-gauge needle is advanced along the wound entrance of the fishhook (**Figure 6**). The direction of insertion should be parallel to the shank. The bevel should point toward the inside of the curve of the fishhook, enabling the needle opening to cover over (capping off) the barb. It is important to have the bevel pointed in the correct direction as shown so that the leading edge of the needle matches the angle of the fishhook barb. Advance the fishhook to disengage the barb, then pull and wiggle it so that the point enters the lumen of the needle. Once covered, back out the fishhook (similar to the retrograde technique), taking care to move the needle along the entry point of the fishhook.

**Figure 6.** Needle cover method. Advance a 16- to 18-gauge needle along the fishhook until the needle opening covers or caps, the barb. The fishhook and needle are then pulled back and removed as a single unit. ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")





A modification of this technique involves sliding a #11 scalpel blade along the wound to the point of the fishhook. The fishhook may then be backed out through the track of the incision line.

### String-Yank Technique

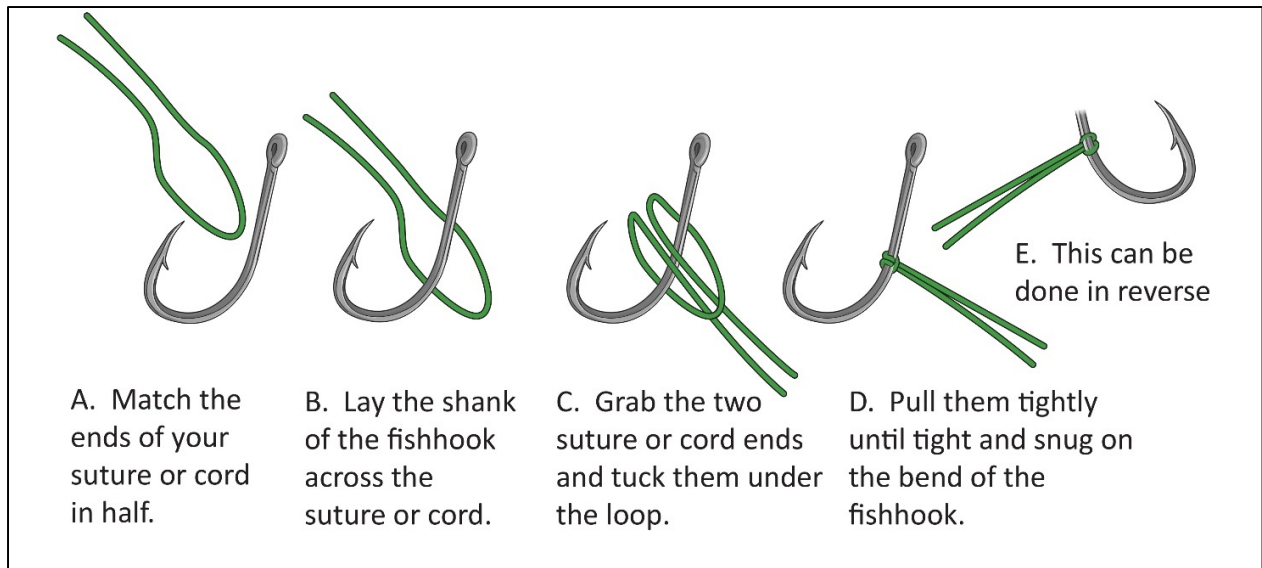
The string-yank technique is a modification of the retrograde technique. It is commonly performed in the field and many fishermen believe it's less traumatic because it creates no new wounds and rarely requires anesthesia. This technique works best when removing small and medium-size hooks. It should not be attempted on deeply embedded fishhooks, for fear of damaging deep nerve and vascular structures, and when the fishhook is embedded in parts of the body that are not fixed (lips, nose, eye lids, ears).



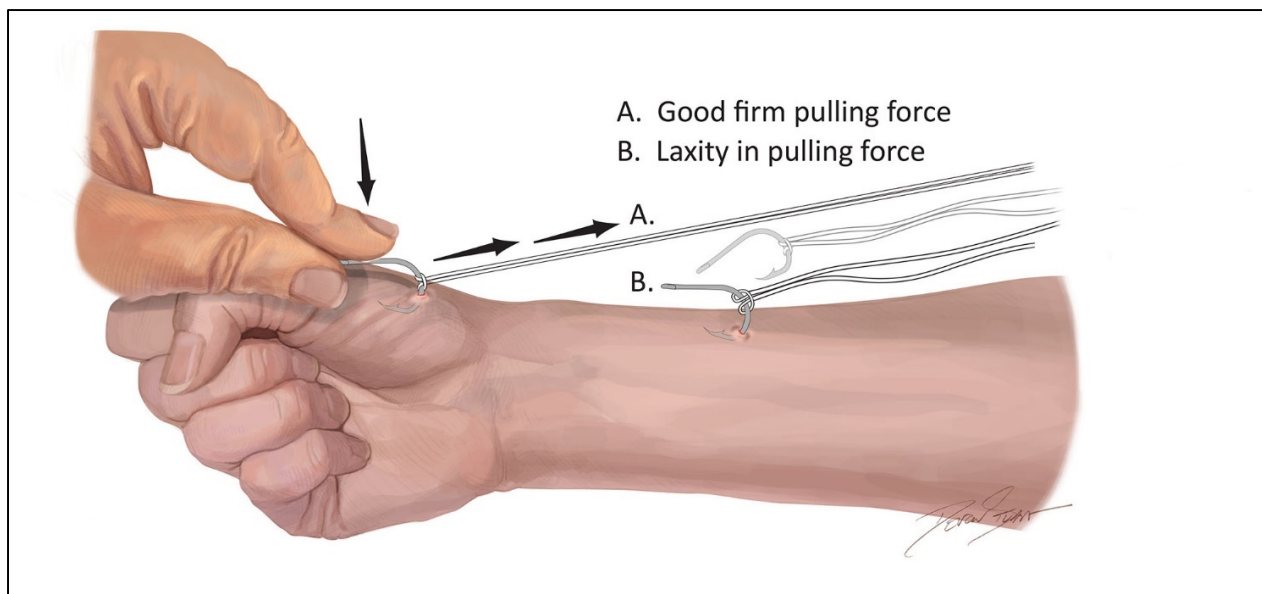
Photo courtesy of Ty Southerland

It has been recongnized that tradition of counting *1,2,3, go* (to give a reference point in time to start) prior to performing a yank-pull attempt, causes most patients to assume a flexed posture, which can cause more damage during the course of pulling. Physicians should be familiar with the concepts of this method. It can become a risky endeavor with improper technique, and may result in permanent tissue and structural damage. A heavy string material (eg, heavy suture cord, or a 20- to 30-pound test fishing line) can be used. Wrap and position the string material around the midpoint of the bend in the fishhook to keep the string in a fixed position, use a simple knot such as a lark's head knot (**Figure 4**). Wrap the free ends around the index finger of the free hand. A better grip on the string can be achieved by wrapping the ends around the gloved hand, grouped tongue depressors, or hemostat shaft. The involved skin area should be well stabilized against a flat surface as the shank of the fishhook is depressed against the skin. Continue to depress the eye and/or distal portion of the shank of the hook, taking care to keep the shank parallel to the underlying skin. A firm, quick jerk (with sustained forceful motion) is then applied parallel to the shank while continuing to exert downward pressure on the eye of the fishhook (**Figure 5A**). Fishhooks extracted with this technique will come out with significant velocity, so the provider and bystanders should remain out of the line of flight and wear protective eye wear (goggles or face shield). Caution should be taken when performing the yank procedure. Keep in mind Newtons third Law of Motion<sup>4</sup>, for every action there is an equal and opposite reaction. This is true when pulling. If there is laxity in the parallel pulling force, the hook can be dislodged from its original position and be forcefully pulled back and then embedded into a new location (**Figure 5B**).

**Figure 4.** Applying a lark's head knot to a fishhook. ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")



**Figure 5.** String-yank method. A: Tie a string using a lark's head knot around the midpoint of the bend in the fishhook. B: Depress the shank of the fishhook against the skin. Press firmly and quickly yank/pull on the string while maintaining continued pressure to the shank of the hook. ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")

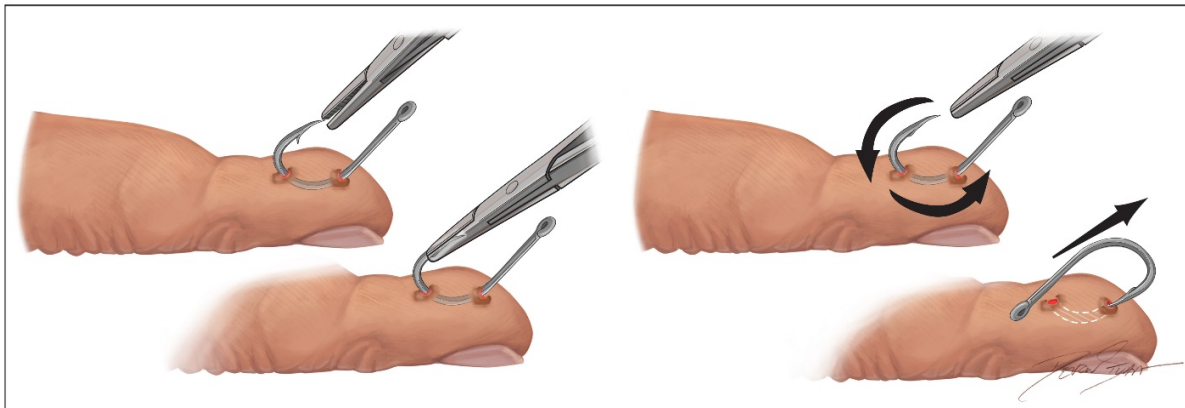


### Barb Crush Technique

The barb crush technique is considered another modification of the Retrograde Technique, but with a higher success rate. Often, there is no wire cutter available. In most cases the available wire cutter may not cut the diameter of the fishhook (shank). Using a pair of pliers or sturdy hemostat you can repeatedly crimp down and crush the fishhook barb flat. Carefully smooth all rough edges, and pull gently, backing the hook out the way it entered the skin. The hook can then be backed out of the skin along the entry path (**Figure 7**).

**Figure 7.** Barb crush method. Repeatedly crimp down hard crushing the barb on the hook until flattened. Next back the hook out the entrance holes.

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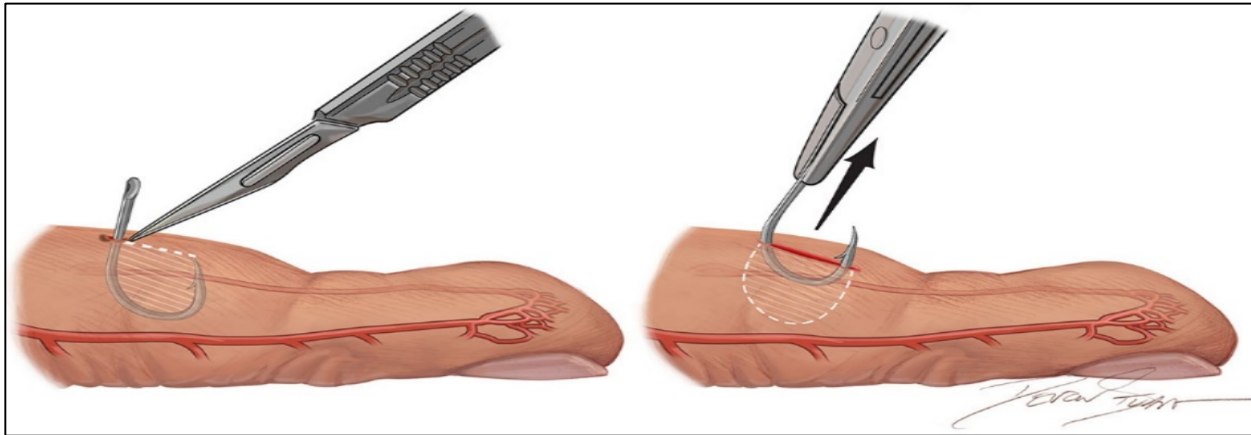
### Cut-It-Out Technique

The cut-it-out technique is useful in penetrating fishhook injury of the fingers. It requires dissection along the shaft of the hook. This procedure is also used frequently by eye surgeons in fishhook injuries penetrating the sclera or cornea.<sup>5</sup> However, this should be a procedure of last resort in the ambulatory care setting, when there is no wire-cutting device available and there is an urgent need to remove the fishhook. This technique is best conducted in an area of superficial penetration, with no major surrounding neurovascular structures or tendons present.

To perform, take a hemostat and pull up gently on the shaft of the hook, in a vertical direction. Next, take a scalpel (preferable a standard #11 blade type) and gently cut along the shaft of the distal end of the fishhook toward the proximal end with the barb. The hook can be then extracted and discarded (**Figure 8**). This technique consequently causes lots of tissue damage, and the resultant scar will likely have a jagged wound edge appearance.

**Figure 8.** Cut-it-out technique. Using a #11 blade pull up and cut along the shaft of the hook in a vertical direction until free of entrapment. ("Illustration ©2020 Devon Medical Art, LLC. Used with permission.")

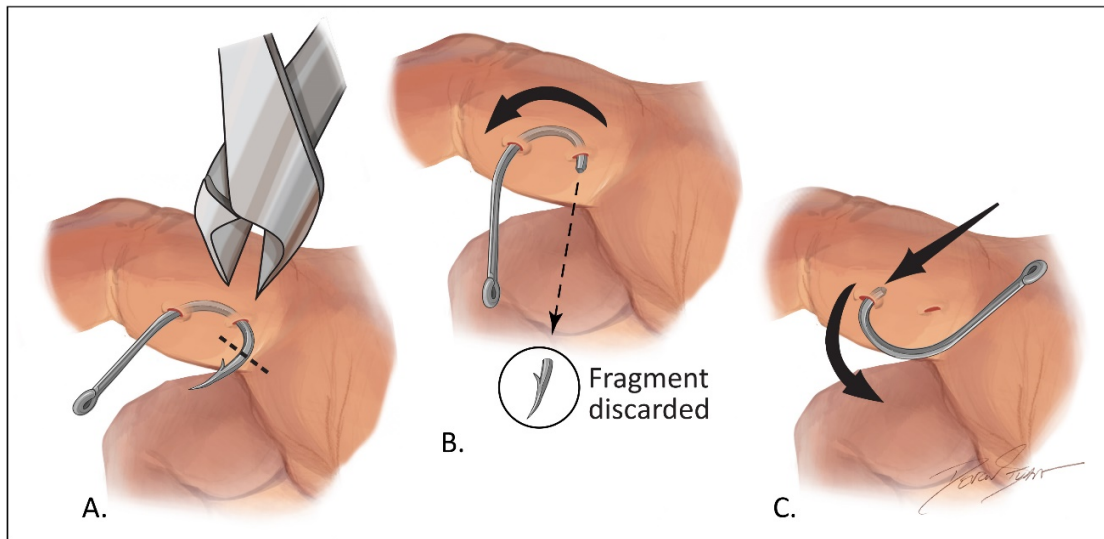




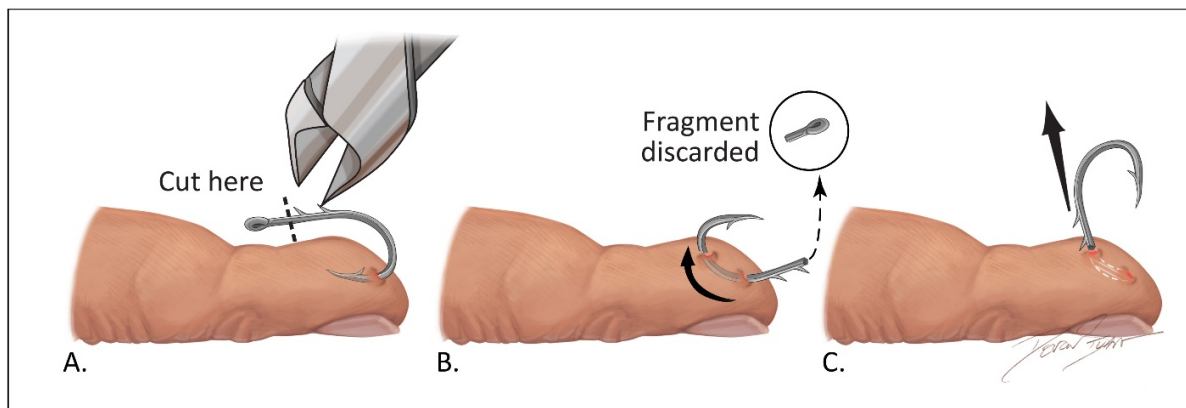
### Advance-and-Cut Technique

This traditional method of fishhook removal has the best success rate, even when removing larger fishhooks; however, additional trauma to the surrounding tissue is caused by creating an exit wound (a slight disadvantage). The advance-and-cut technique is most effective when the point of the fishhook is located near the surface of the skin.<sup>6</sup> It involves two methods of removal: one for single-barbed fishhooks (**Figure 9**) and one for multiple-barbed fishhooks (**Figure 10**) where the non-embedded hooks are cut off or taped over, prior to attempting removal. Infiltration with a local anesthetic is performed over the area where the fishhook has penetrated the skin, alternatively a digital or regional block may be appropriate for various body site injuries.<sup>7</sup> Using a hemostat or needle driver, with a strong grip and twisting motion of the wrist, drive the point of the fishhook (including the entire barb) upward through the skin, creating an exit wound. A modification of note is to open the skin with a #11 scalpel blade, slightly above the tenting point of the hook to allow easier exit. Once the distal shaft of the fishhook completely clears the skin surface, cut it with a medical wire cutter or another cutting tool, allowing the rest of the fishhook to be backed out with little resistance. Protective eyewear should be worn by provider and bystanders. Fishhook fragments fly off with massive force and can cause bodily injury. The advance-and-cut technique is likely to be the most universally accepted in the emergency room, ambulatory care, and urgent care settings, as it is probably the most familiar to providers and least anxiety-producing for the patient. If by chance the fishhook has several barbs on the shaft, the distal end (eye) should be cut off with a wire cutter and the proximal end with the hook pulled forward through the exit wound. Devices specifically designed for this purpose are available. All wire cutters have a limit of diameter cutting capacity and in cases involving larger fishhooks, patients may have to be referred to the emergency room or hospital where a bolt cutter or surgical procedure may be required.

**Figure 9.** Advance and cut method: single-barbed fishhook. (A) Advanced the fishhook through the skin creating an exit wound. (B) Cut off the barb of the fishhook (C) back the remaining fishhook out the entry point. ("Illustration ©2021 Devon Medical Art, LLC. Used with permission.")



**Figure 10.** Advance and cut method: for multiple-barbed fishhook. (A) Advanced the fishhook through the skin creating an exit wound. (B) Cut the eye of the fishhook off and (C) Pull the remaining fishhook forward through the exit wound created by advancing the point through the skin. ("Illustration ©2021 Devon Medical Art, LLC. Used with permission.")



### POST-REMOVAL WOUND CARE

After removal of the fishhook, the wound should be irrigated thoroughly with normal saline. All debris and foreign bodies should be removed. Finally, the wound should be covered with antibiotic ointment (mupirocin) and a sterile dressing. Wound care should include routine irrigation, cleansing (betadine), application of antibiotic ointment, and dressing change on a daily basis or every other day. Observations should be made for signs of infection such as edema, erythema, purulent drainage, etc. Healthy patients with uncomplicated skin injuries should be advised to soak the wound in warm water two to three times a day until healing is observed.

Infections after fishhook removal are uncommon.<sup>1</sup> Therefore, routine use of antibiotics for uncomplicated superficial skin injuries is not indicated. For the rare cases in which there is reason

for suspicion of infection and antibiotics are prescribed, consideration of coverage water-borne organisms is reasonable.

Patients should also be evaluated for tetanus prophylaxis. Tetanus-diphtheria or tetanus-diphtheria-pertussis (Td or Tdap) vaccine should be administered if there is a history of less than three doses or unknown doses of tetanus toxoid administration. If the last dose of tetanus toxoid was received within the last 10 years, then no further vaccination is required.

## CONCLUSION

Fishhook injuries can occur at any time, during angling, commercial fishing, or simply cleaning out the garage. To bring about a renewed approach to fishhook injury and advancing medical treatment strategies, it is imperative to track valuable incidence data. There is also a need to establish a basic minimal procedural understanding by all healthcare providers involved in emergency rooms, ambulatory care centers, and urgent care centers for quick assessment and swift removal of fishhooks. This is an area where risk recognition has to be appreciated to prevent injuries to patients and providers. The best approach is to be knowledgeable of the anatomy of the injured area and be prepared mentally to make adjustments in your procedural method. Always consider starting with the simpler removal techniques (ie, retrograde, needle cover) prior to the more robust methods mentioned in this article. Lastly, there is a need to establish a standard fishhook removal system that is as universal as the suture tray, containing a medically approved cutting device, along with hemostat, protective eye wear, and other supportive care supplies. Ensuring there is an established protocol, provider training, and a ready-to-use fishhook removal system on hand (ideally in close proximity to a laceration repair kit) will increase the likelihood of both a positive clinical outcome and high patient satisfaction.

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**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT S  
TO COMPLAINT FILED  
FEBRUARY 28, 2023



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# AN URGENT CARE APPROACH TO FISHHOOK REMOVAL

It has been brought to our attention that the publication titled "An Urgent Care Approach to Fishhook Removal" originally published in June 2021 digital edition of The Journal of Urgent Care Medicine on June 1, 2021 ("Publication"), contains several changes made during the editing process performed by JUCM which the authors took issue with and subsequently demanded the Publication be retracted. Accordingly, at the request of the authors, Anthony G. Stanley, MD and Jorge Murillo, MD, we have fully retracted the Publication.

Uncategorized

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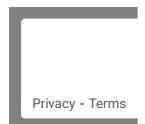
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**UNITED STATES DISTRICT COURT FOR THE  
SOUTHERN DISTRICT OF FLORIDA**

**MIAMI DIVISION**

**CASE NO.** \_\_\_\_\_

ANTHONY STANLEY, M.D.

Plaintiff,

vs.

THE BRAVEHEART GROUP, LLC, a New Jersey  
Limited Liability Company, d/b/a  
THE JOURNAL OF URGENT CARE MEDICINE, and

EXPERITY INC., an Illinois Corporation, d/b/a  
EXPERITY HEALTH, and

URGENT CARE ASSOCIATION, INC., an Illinois  
Corporation, d/b/a  
URGENT CARE ASSOCIATION, and

URGENT CARE COLLEGE OF PHYSICIANS, INC.,  
an Illinois Corporation, d/b/a  
COLLEGE OF URGENT CARE MEDICINE.

Defendants.

\_\_\_\_\_ /

EXHIBIT T  
TO COMPLAINT FILED  
FEBRUARY 28, 2023



From: <[swilliams@jucm.com](mailto:swilliams@jucm.com)>  
Date: Wed, Oct 13, 2021 at 11:07 AM  
Subject: RE: Retraction of Article  
To: Alex Loveyko <[alex@chaselawyers.com](mailto:alex@chaselawyers.com)>

Alex,

Thank you for your note. Per our general counsel, attached please find the redline and clean versions of the retraction we will be publishing online shortly and in our next print edition. Further, per our general counsel, we will not be re-publishing the article out of an abundance of caution to avoid the potential confusion to the public. With publication of the full retraction, we consider this matter finalized.

Best,

Stuart

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